

FIRST-TIME MOTHERS' EXPERIENCES AND
THE PERCEPTION OF NURSES' PROVISION OF
POSTNATAL CARE

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DECLARATION

I hereby declare that this thesis has been composed by myself and that the research on which it reports is my own work.

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May 2005

ABSTRACT

In this study I explore and describe first-time mothers' initial experiences of motherhood and postnatal care. The women selected were in-patients in a postnatal care setting in Switzerland. The women's expectations of motherhood and postnatal care were investigated through conversations prior to birth. Further data about their experiences and postnatal care provision were obtained from conversations with participating women and nurses, observations of day-to-day practice and related documentary materials during the six-month period of fieldwork. Follow-up conversations were conducted after discharge. For its theoretical underpinnings the study draws especially on the theory of 'becoming a mother' by Barclay and colleagues (1997) and on Swanson's theory of caring (1991; 1993).

The data analysis was organised around two main themes: experience of 'being on postnatal journeys' and 'caring relationships'. The women's initial journeys into motherhood were intertwined with their journeys through the postnatal unit. The study explores the tensions and discontinuities between these two journeys, notably in relation to the availability of competent care and support; the mothers' requirements in terms of recovery and recuperation; and the tensions between individualised and routinised care. It identifies the extent to which women were able to regain physical strength, attain competence and develop confidence as caring mothers during their days in the unit. The study also explores how women anticipated their return to life at home with their baby and experienced the process of discharge. The second main theme concerns caring relationships. The study investigates these from the perspectives of the nurses and the unit's mission as well as those of the first-time mothers. It identifies how the participating nurses and first-time mothers related to each other as well as examining continuity and consistency in care provision. The study further explores the tensions of structural influences on care provision and first-time mothers' and nurses' satisfaction with received and provided care respectively. This study specifically raises the issues of fragmented care provision, a lack of family-centeredness and the anxiety that arises at discharge. It further calls into question whether in-hospital postnatal care as it is organised and structured today is still appropriate. The findings of this study will be useful in effecting change in the provision of postnatal care to women and their families, and implications for nursing practice and education as well as research and policy are therefore highlighted.

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INTRODUCTION

This thesis is an exploration of women's experiences as they become mothers for the first time. It examines the care a group of women received from nurses on a postnatal care unit in a General Hospital in the German speaking part of Switzerland. Care for mothers had attracted my attention long before I entered nursing in 1974. I grew up at a time and in an environment where home birth was the norm (as I describe on pages 118/119). This personal experience of postnatal care in the home contrasted with what I learned about in-hospital postnatal care in my professional life. When I began to work as a Clinical Nurse Specialist in the Clinics for Gynaecology and Obstetrics, my interest in postnatal care developed further. While working with postnatal care nurses, I became aware of the complexity of their work and the challenges they faced in this segment of nursing care. During that time I also became aware that provision of postnatal care was not highly regarded by other professions involved in the care of childbearing women. Some encounters I had with professionals revealed views that reflected the notion that becoming and being a mother was an easy and fulfilling task.

In addition to what I was seeing in clinical practice, I also became aware of how historical and demographic development had influenced the structure of maternity care services. However, I was unable to find information about these areas in the German language nursing research literature, with Lind-Keel (1993) and Schiemann (1993) being notable exceptions. My attention therefore was drawn to related fields focusing on the social and psychological processes which are characteristic when women become mothers for the first time. Despite these relevant areas, my professional background led to the decision to remain within the field of nursing. Attracted by the grounded theory study on *Becoming a Mother* published by an

Australian research group (Barclay *et al.*, 1997; Rogan *et al.*, 1997), I continued searching for more knowledge relevant to the area and a way to combine such knowledge with practice.

This study of the exploration of postnatal care for first-time mothers intends to capture their experiences and the nature of care, however it will always remain “partial and incomplete” (Wolcott, 1999:16) as I will describe in Chapters Three and Seven. I also seek to investigate the relationship between theory and practice for myself, that is, in my attempt to be an engaged social researcher. This thesis consists of seven chapters following this introduction. Before commenting on the content of each chapter, I will introduce the reader to the problems, aims and context of this study and mention issues of specific use of terminology.

Importance of the Study

Becoming a mother for the first time is an individual experience. However, it is widely assumed that every woman can cope easily with the changes that this brings with it. Producing children, although a personal interest, is also a socio-political asset contributing to the continuous existence of human beings and society. Supporting women in the transition to motherhood is therefore a societal responsibility. Such a perspective places nursing in a prominent role since nurses are the primary caregivers in the early postnatal phase within this hospital culture. This specific segment within maternity care is the focus of attention in this study.

In the Western world, maternity care has undergone tremendous changes over the last decades. The most significant of these has been the process of medicalisation of childbirth as a result of technical improvements driven by the high rates of maternal and infant mortality but also by the increased involvement of the medical profession in childbirth assistance. Power and control and the belief of betterment resulting from shifting professional responsibilities has eroded midwives’ autonomy. Concomitantly childbearing has been moved into hospitals and subsequent postnatal care has been provided in such institutions. Within the cultural context of this study, women still stay in hospital up to five days after an uncomplicated vaginal birth. More recently,

and strongly influenced by the changing political climate in health care, shorter hospitalisations in general and in particular post-birth have been proposed (Beck and Knoth, 2003). However, professional support for families in the early phase post-birth needs to be established to move postnatal care provision successfully from the hospital to home and to the community. While this is a secondary interest of this study, the focus is on first-time mothers, their experiences of being a mother and of postnatal care provision, and on nurses in this setting, specifically how they perceive and respond to women's needs.

The problem I became aware of while in practice was that postnatal care lacked an informed understanding of the transition process women undergo when they become mothers. Such a deficit inevitably resulted sometimes in inadequate care provision. To better understand the process of postnatal care, I decided to investigate this broad field, focusing on first-time mothers while they were in hospital and the nurses caring for them.

Aims of the Study

The aims of this research are to explore postnatal care for first-time mothers in a specific postnatal care setting, to identify women's expectations influencing their care needs and how they experienced care provision. Furthermore, nurses' perceptions of women's needs and their responses to those needs are to be explored. Finally, this research aims to inform nursing and policy-makers about requirements necessary for a successful change. The underlying assumption of the ethnographic research approach fits with the research aim of developing an understanding of the complexity of in-hospital postnatal care and recognising socio-cultural and organisational influences.

Use of Terminology

It is important to clarify terms of address at this point. When nurses talked about women to me, they would refer to them as "Ms X" or the mother of "Baby Z". For

that reason and whenever appropriate, I tend to use the word “woman” as this reflects the view of the health care professionals working in this field. The use of the terms “mother” or “first-time mother” is appropriate in many places and the latter recognises the woman’s role in this first event, distinguishing her from an experienced mother. When women talked about nurses to me, they would use the term “nurse” but when they were referring to a specific nurse, they would address the nurse by her family name; for example “Ms Y”. Nevertheless I use the term “nurse”. Throughout this thesis I also use the terms “nursing staff” when I refer to this specific professional group, but “health care professionals” or “care providers” when I address one or several professional groups. “Care receivers” is used to address a group of women within that setting. The term “participants” refers to both the women and the nurses participating in this study.

The Structure of the Thesis

This thesis is unavoidably written in a linear fashion which cannot adequately reflect the process by which I developed an understanding of the research questions. In particular, my understanding of the theory of the social construction of reality developed in parallel with my experiences of and reflections on my fieldwork. When I went to the particular study field, I had the feeling there was something important to do with; involving in the dialectic of postnatal care and the construction of care. However, at the time of doing my fieldwork this was only a vague idea and I could not have formulated it in the way in which it now stands.

In Chapters One and Two, I introduce the literature relevant to the topic. In Chapter One, I focus on motherhood and the psychological and socio-cultural processes of becoming and being a mother whereas in Chapter Two I introduce and discuss care and support in the early postnatal phase. The majority of the literature used in this thesis originates from English-speaking countries, with some from Continental European countries. The disciplines contributing knowledge to my understanding of the subject under study are numerous, however nursing and midwifery literature remains dominant.

In Chapter Three, I consider the methodology which was used for my fieldwork and analysis. I outline the research procedure and give insights into the steps taken with this ethnographic inquiry within a postnatal care setting. Thoughts are given to analysis, ethical questions, the researcher's background and trustworthiness within the chosen approach.

Chapter Four outlines the context in which this research took place. A brief introduction informs the reader about relevant aspects of the Swiss health care system. This is followed by a description of the research setting, how it is organised and populated and its policies. A personal account is also presented as a contrasting context of birth within this culture.

'Being on postnatal journeys' and 'caring relationships' are the two data chapters: Chapters Five and Six. The analysis presented in Chapter Five shows the intertwined journeys of women as they were becoming and experiencing being a first-time mother while they were on the postnatal unit. Chapter Six presents aspects of the woman-nurse relationship, such as continuity of care, how these affect care provision and the connection to personal as well as professional support networks.

The final chapter includes reflexive notes on the research process. I conclude my thesis by discussing my findings and draw implications from this new knowledge for nursing, further research and policy.

CHAPTER ONE

MOTHERS AND MOTHERHOOD

Introduction

Issues of motherhood and postnatal care are of interest to a diverse range of disciplines including sociology, psychology, anthropology, medicine, nursing and midwifery. Whilst literature reviewed in this chapter is not solely limited to nursing and midwifery, publications from these disciplines remain the focus of the review since these two professions have long been associated with direct care of childbearing women. Geography is another factor considered in constructing the literature review. Relevant literature from Australia, New Zealand, North America, the United Kingdom, South Africa and different continental European countries is also reviewed since the current study occurs in the context of the developed Western world. Initially, research-based material was identified using the databases Medline, CINAHL and BIDS. Keywords most used were ‘motherhood’, ‘first-time mothers’, ‘postnatal care’ and ‘support’. After consulting literature identified in this way, further studies were accessed by examining the references contained in various publications and through conducting searches on the Internet. The majority of literature contained in this review is research-based. However, in recognition that there are valuable reports and essays on the experience of motherhood and related issues which are not research-based, other literature is also used.

The aims of the literature review were firstly, to describe existing knowledge of early motherhood, needs of first-time mothers and support and care provided by health care professionals in the hospital setting. Secondly, it was important to discover what

work had been conducted relating directly and indirectly to the research interests; thirdly, to analyse the literature and to find interrelationships between publications. Finally, it was important to review the written material in terms of content, method and theoretical perspective in order to assist in the development and justification of the research questions.

This chapter has four sections and begins by describing motherhood and how this concept has developed over time and been influenced by social changes. Following this is an outline of the process of becoming and being a mother, including an introduction to relevant theories which conceptualise this process. The third section aims to explain how maternal identity is attained by women, and how this process occurs both internally and externally. Finally, the experiences of early motherhood are addressed, including informative research findings.

The Concept of Motherhood

This study is concerned with the issue of postnatal care of first-time mothers, therefore it is important to give a brief insight into the historical development of the concept of motherhood to provide the background to contemporary issues. The concept of motherhood is constructed through cultural and social discourse and therefore varies across time and culture. Motherhood is constructed through an amalgam of old and new trends, traditions, and reactions to societal portrayals including both understandings and misunderstandings of the construction (Dally, 1982). Becoming a mother is a biological, psychological and social process, which occurs over time and comprises individual experiences, influenced by a variety of factors.

Whereas “the word ‘mother’ is one of the oldest in the language” (Dally, 1982:17) the term “motherhood” first appeared in the late 16th century and emerged as a concept in the 19th century. *Me* and the *other* lies in the word mother or as Martin Buber states, the *I* and *thou* as two relational subjects perceiving each other as unity of being, and engaging mutually and reciprocally (Buber, 1970). Each society,

culture and era has its own definition of motherhood and these definitions are bound both by prospects and limitations.

Evolution of the social construction of motherhood

Although the role of mother is an age-old one, the concept of motherhood and thus the act of being a mother has changed considerably over the centuries. Throughout history, and into the present the role of mother has been central to women's identities, occupying a central position for many women. In recent times feminists have taken on the issue of motherhood in differing ways. Some feminist writers challenge the popular view that motherhood is a state to be aspired to by all women. Rich (1986), a prominent writer on the subject, views motherhood as a patriarchal institution that confines women. An alternative view is that it is important for women to understand the biological capacity of childbearing as a unifying and liberating force (Kirkley, 2000).

Throughout the literature little is revealed about the actual nature of the work of mothering, or about women's acceptance of their assigned role and the mother-child relationship in any historical epoch. More recently historians have given some attention to these issues, though as Kaplan (1992) says, doubts will always remain due to lack of historical evidence. Mander and Marshall (2003:237) indicate that in the 17th century women were taught that "it was their duty to bear large families". However, childbearing rather than childrearing was what was central in women's lives. It became of increasing interest to medicine and to philosophers such as Rousseau in the late 18th century. As demonstrated in his book *Émile* (Boyd, 1956) it was no longer possible to confine issues of childrearing to the private sphere. Infant mortality was high and this came to be seen not only as a personal tragedy, but also an economic one, as well as a health related issue for society at large. The development of the Welfare State and technical advancement in assisting childbirth gave rise to the larger involvement of the medical profession in the control of the birth rate.

Cudmore (1997) notes that prior to the 18th century that the idea of childhood as a special time with specific requirements best provided by mothers had not yet emerged. She suggests, “although women gave birth to many children, caring for them was not a central part of the motherhood role” (Cudmore, 1997:1). Cudmore argues that only in the middle of the 19th century, when childrearing became an important societal concern, did it become a central part of the motherhood role. Although, as with the present, there were differences in perceptions of motherhood amongst the social classes, beginning with the Victorian period motherhood and childrearing became a domestic ideal and tremendous pressure and expectations began to be placed on mothers.

With the move into the mid-nineteenth century the conduct of mothers was increasingly dictated by societal norms. Motherhood was not really a choice as women had a duty to produce heirs, but it paved their way into adulthood. Additionally, and as Milne (2003:1) states in her essay about Victorian Motherhood, mothers had “to follow medical books for wives, mothers and newborns, as well as use new products on the market for mother and baby”.

In Victorian society, women were largely treated as second class citizens. They were expected to fulfil their ‘natural’ duties of wives and mothers and it was assumed without question that they were the social and economic dependants of men. The condition of motherhood varied widely depending on social status. The Industrial Revolution brought about the growth of large towns and cities where living and sanitary conditions were appalling, resulting in high death rates, particularly among children.

For the working classes large families were an economic necessity. Mothers were forced to combine childrearing with their daily work in factories. For middle class women life was somewhat easier. Poverty was not an integral part of their lives. However, they still shared many of the problems of working class women. The social perception was that motherhood should be their true vocation in life.

Nevertheless throughout the 20th century pressure grew from women for more political, economic and social freedom. The work of the Suffragettes, and the changed social and economic status of women following the First World War

brought demands for changes. In Britain organisations such as The Women's Co-Operative Guild argued that it was essential to alleviate the difficulties experienced by mothers. It was the duty of the country.

To relieve motherhood of its burdens, to spread the knowledge of mothercraft that is so often lacking, to make medical aid available when it is needed, to watch over the health of the infant. And since this is the duty of the community, it is also the duty of the State (The Women's Co-operative Guild, 1980:vii)

This duty of the State progressed slowly however, and it was not until the introduction of the National Health Service in 1948, that free hospitals and medicine for example became available to all citizens in Britain. It is from this point that the practice of homebirths declined with the vast majority of births now taking place in maternity hospitals. This brought about a differing philosophical and medical approach to childbirth and motherhood.

In the latter half of the 20th century women faced many changes including having the choice to become a mother. Motherhood was much debated within the feminist movement which challenged the contemporary image and the idea that it was something to be aspired to by every woman. Furthermore, educated women started to evaluate their responsibility and their role within society. They could choose when to become mothers and limit the number of children they had as was never possible before.

Women today have fewer children and they also have them later (Cudmore, 1997; Devlin, 1995). Much debate surrounds the role ascribed to women by society as the primary carer of children, as well as their financial contribution to the running of the households. The number of women combining the responsibilities of motherhood and full-time paid work has increased over the past decades. Despite involvement in the labour force, the mother's nurturing role continues to influence our ideas about motherhood. Many women leave the work force, at least temporarily, when their first child is born, but a large number also return to their jobs following birth. Replacing a fulfilling job with the exhausting and isolated task of new motherhood can be a frustrating experience for some women (Devlin, 1995).

The contemporary social construction of motherhood

As a biological process, motherhood is universal and has remained constant despite the many medical advances and attempts to manipulate this process. As a social construct however, motherhood varies over epochs and cultures. How it comes to be represented in a society reflects how it is organised and carried out within the cultural context (Kaplan, 1992). Rich (1986) argues that males have usurped the conception of motherhood as an experience and an institution. She uses the term 'institution' as it relates to the social and political function of motherhood. Reproduction fulfils aims and ideals of societies and within this view motherhood is restricted to responsibly satisfying those demands. Such a stance ignores women's authentic human rights and powers and gives rise to male dominance (Bergum, 1989; Rich, 1986). Rich (1986:11) argues that men were envious of women's reproductive powers because they realised that "all human life on the planet is born of women" This might explain why medicine, a male dominated profession assumed control of childbearing.

The powerful emotional experience of motherhood puts women in touch with their own bodies, their feelings and their children. This individual aspect of motherhood is excluded from institutionalisation. Rich (1986:13) says the meaning of this experience is "the potential relationship of any woman to her powers of reproduction and children". Women's reactions to motherhood, although culturally influenced, are not universal experiences (Richardson, 1993); they are as individual and varied as the number of women who become mothers. Such reactions can range from feelings of happiness and fulfilment to distress and cheerlessness (Ball, 1987). Their experiences go beyond reproduction and are more than a functional and natural phenomenon (Chodorow, 1978).

Whether as a conscious or an unconscious process, society constructs motherhood by focusing on specific images rather than experiences. Patriarchal ideology expects women to see the bearing and rearing of children as their exclusive purpose and to find satisfaction in this role (Glenn, 1994). Motherhood is at first glance a much admired societal role, but it is also an over idealised one (Welldon, 1989). It is also seen as a social duty (Doyal, 1995) and its worth is defined by the relevant society

(Oakley, 1980). Ideologically, simplifying women's capacity to biological reproduction rejects other identities and selfhood outside mothering (Glenn, 1994). There are explicit expectations of women to become mothers (Laryea, 1989) and implicit ones about what is good or bad behaviour for a mother. There are notions about the ideal age, marital status and engagement in childrearing or division of labour (Littlewood and McHugh, 1997). To be qualified and respected as an ideal mother means to fulfil the expectations and conditions of a society's ideology (Welldon, 1988). Rich argues that when motherhood is idealised there is the potential for women to be kept in inferior and subordinated roles and this serves the goal of male domination by keeping women in their place. Glenn (1994) reasons that since medicine is clearly dominated by men, male domination over women is achieved through medicalisation of childbirth, whereby male power is imposed on a female process. Harcombe (1999) concurs, suggesting that patriarchy and the medical profession, as a product of it, clearly demonstrate power over women during the process of birth.

One consequence of the medicalisation of childbirth is the widespread practice in Western societies of giving birth in a hospital. In any journey through a hospital, as Pizzini (1989) argues, the social order is characterised by medical procedures, hospital facilities, use of medical devices and technical language. Even if staff in hospitals intend to see birth as a normal physiological process, the setting undoubtedly defines the process as an illness. Whilst some women do have health problems during pregnancy, birth and post-birth, such a stance is not justified for the majority of childbearing women. By emphasising ill health and pathology, medicalisation results in a one-sided picture.

It is not only the technology related to childbirth that contributes to medicalisation. The image is also reinforced through specific interactions of all members of staff (Pizzini, 1989). Although women are asked to participate and to contribute to decision-making surrounding birth, the construction of routines and unwritten rules of hospitals denote certain behaviours to which a woman and her caregivers, be they nurses or midwives, are expected to conform. Nurses and midwives do not practise in a vacuum. Through professional socialisation it is very easy for nurses and midwives to become part of the medical guild. They promote methods of mother and infant

care that they believe serves them best within the contemporary political and economic situation. The service they deliver reveals the current image of motherhood and family. Nursing and midwifery practice often reflects the norms of a society and as such it may not necessarily represent the best interests of new mothers.

An example of the mirroring of medicalised practice in midwifery is demonstrated in a study by Laryea (1989). She investigated midwives' and women's perceptions of motherhood, the needs of newly delivered women and the midwives' methods of assessing these needs. She found that in defining the meaning of motherhood there was a fundamental difference in the perspectives of midwives and mothers. Midwives emphasised the biological and medical aspects of motherhood. They perceived childbirth as a normal phase of a woman's life cycle and a marker of physical maturity. Whilst midwives recognised that their role involved handing over the responsibility of caring for the newborn child, their emphasis was on ensuring the mother was in a good physical state. Laryea's (1989) findings reflect the medical paradigm in postnatal care. Medical and social sciences, as Oakley (1980) for example suggests, have strongly influenced the position and identification of mothers. She claims that "cultural femininity and biological reproduction are curiously synonymous in the proclamations of medical science about women" (Oakley, 1980:50) but psychology and sociology have also sustained that image.

Becoming a mother is framed in societal contexts and motherhood becomes decontextualised from the individual experience of the woman and is determined by society. Another example of how the medical model of childbearing frames motherhood is the extent to which lay people refer to technical terms and use medical language when narrating their birth experience (Miller, 2000). Pizzini (1989) notes that throughout the process of childbearing a woman goes through three stages: medicalisation, desexualisation and depersonalisation. Oakley (1980) also notes that on the journey of childbirth the woman's body becomes a technical object to professionals. She suggests that this is done to make birth of a child manageable and to help professionals refrain from engaging with the intense emotions involved.

The social construction of motherhood powerfully influences how women are perceived within a society. This inevitably leads to certain behaviours and reactions, which ultimately constitute the role of mother.

Motherhood as a role and as a crisis event

Becoming a mother means fulfilling a sociological role (Chodorow, 1978). The concept of role is a sociological one and it combines a normative and a behavioural dimension, (Nye, 1976) which vary depending on time and cultural development. Because of overuse of the word role by different social sciences, how a society characterises role has been debated. However the theoretical construct of role has not been disputed.

The role of motherhood is one of several, unique and distinct from the other roles a woman holds in family and society. Motherhood as a role can be perceived as a unifying force conferring a group membership that can assist women in establishing new relations and strengthening emotional feelings (Smith, 1995). Socialisation as a mother is derived from the woman's own experience of how she was mothered as a child and directly from role models during pregnancy and in the early postpartum phase (Rubin, 1967a). Chodorow (1978:31) also suggests that "feminine role training and role identification" contribute to role identification as a mother. At one time, the majority of the society believed that maternal instinct was essential in taking on the role of a mother (Haldane, 1927). Similarly, and this applies to more recent times, Welldon (1989:139) argues society expects that mothers come to the fore with their maternal instinct and to perform miracles, irrespective of their upbringing. However Badinter (1981) disputes the existence of maternal instinct and argues it appears most women are ill-prepared to assume the role of mother. Maternal love on the other hand is a feeling, "uncertain, fragile and imperfect" (Badinter, 1981:xxiii) but is likely to develop in women as they assume motherhood. In addition, not all women have a biological drive to conceive, bear and nurture children, and skills to care for children are not necessarily evolved immediately after birth (Nicolson, 1998). Premature or ill babies can provoke problems for women as they have to re-conceptualise their assumed mothering role. Normative prescription and scientific

knowledge inform women's common understanding of their role. Deviations in complying with these norms are readily pathologised.

The image of joyful and fulfilled motherhood is a pervasive one. Postnatal adjustment to motherhood involving fulfilling roles as a partner and succeeding in mothering the child is readily expected. However, women's self-esteem and confidence are challenged in this adjustment process and there is a dark side to motherhood which may remain hidden. Many women believe that to talk about negative feelings would be an admission of failure.

The birth of a first child is a disruptive event in a partnership and requires major reorganisation. However, new motherhood is seen as a period of transition with which women should cope easily. Medical literature tends to describe changing moods during childbearing and the subsequent transition to motherhood as a crisis. It is indisputable that birth is a stressful event involving traumatic experiences such as grief and bereavement, however, conceptualising it as a crisis has been challenged. The term crisis connotes distress and is mainly used to portray very negative events. In the context of conceptualisation of identity Erikson (1968:16) reasons for a more careful use of the word and suggests:

It may be a good thing that the word 'crisis' no longer connotes impending catastrophe, which at one time seemed to be an obstacle to the understanding of the term. It is now being accepted as designating a necessary turning point, a crucial moment, when development must move one way or another, marshalling resources of growth, recovery, and further differentiation.

With reference to Erikson (1968), the movement from woman to mother involves a state of crisis, however transitional periods such as becoming a mother can be qualified as developmental crises.

Rossi (1968) suggests that labelling a normal physiological process, such as pregnancy and birth, a crisis, pathologises it because of the negative connotation of the word. She suggests the use of the word 'transition'. However, arguing for or against applying the term crisis or transition is rather rhetorical as it is well accepted that becoming a mother has a tremendous emotional impact on women. Erikson's developmental crisis seems appropriate since crisis marks a turning point in a person's life (Concise Oxford English Dictionary, 2001). The mildest form of mood change is known as the 'fourth-day blues', 'baby blues' or 'maternity blues' (Laryea,

1984; Nicolson, 1998). These upset feelings are temporary, self-limiting and the mother recovers after a few days. Nicolson (1998:55) reports that 95 per cent of women in her study experienced some form of “depression, anxiety or weeping”, which is in line with clinical results. Constraining feelings and ineffective coping with the event of childbearing can result in postnatal depression and Nicolson (1998:98) sees this not as pathological but rather as “potentially a healthy, grieving reaction to loss”. However, this depressive reaction to motherhood might be threatening especially for other people in the woman’s social network. Yet, there is not a significant difference between rates of depression in new mothers and non-childbearing women (O’Hara et al., 1990 in Barclay and Lloyd, 1996). Post-birth, a small percentage of women experience emotional disturbance as severe as a psychosis. Women with these illnesses need psychiatric treatment and intensive support from their social network and professionals (Laryea, 1984).

By relating to the history of motherhood, and by being reminded that ideas about motherhood have developed over the centuries, the contemporary construction of the concept is brought into perspective. The process of becoming a mother is powerfully influenced by male dominated medicine and it is demonstrated how women comply with institutionalised procedures. Women fulfil an important role in our society but women’s individual experiences are not recognised. The next section illuminates what is involved when women become mothers.

Becoming a Mother

The transition to motherhood has been studied widely across several fields including nursing, where researchers have described the process in terms of ‘maternal role attainment’ (Mercer, 1981; 1985; 1986; Rubin, 1967a; 1967b). The journey to motherhood is a process constituted of different phases as Cudmore (1997:31) converses in reference to Bergum (1989) and “perhaps the most important aspect of the transformation of woman to mother is the moment of childbirth itself”. The physiological process of childbirth initiates a new life cycle, however the process of transition precedes that event. Since the focus of this nursing study falls within the

broad topic of becoming a mother for the first time, it is important to explain the theoretical background of transition and maternal role attainment from a sociological, psychological and nursing perspective.

Transition and maternal role attainment

The early postnatal period, which is the focus of this study, is a time of development and change for every woman. This is a challenging time and requires adjustment on a physiological, emotional and social level. The initiation of this transformation however begins much earlier. The literature on adaptation to motherhood offers different theories with different time perspectives. From a sociological perspective, theories on transition with emphasis on the psychosocial and behavioural aspects are introduced by Rossi (1968), Burr (1972) and Burr and his colleagues (1979). Nursing research literature depends on and refers to sociological theories. Maternal role attainment, a theory widely used in Nursing Science literature, stresses the cognitive and subjective experiential aspects (Mercer, 1985; Rubin, 1967a, 1967b). Since the theories 'transition to motherhood' and 'maternal role attainment' describe the same process it seems important to outline both perspectives as the emphases are different.

Definition and process of transition

Transition implies a change or passage from one life state to another, the experience of a journey through a life span, or "a brief and unstable period between human developmental stages" (Brammer, 1991:4). Transition as a whole is understood as a cyclical process and each phase has its unique characteristics and problems (Rossi, 1968). Burr (1972:407) describes role transition as a "process of moving in and out of roles in a social system". A transition process is characterised by "addition or termination of a role without any change in other roles; or it could be the termination of one or more roles and the concomitant beginning of another" (Burr, 1972:407). Daily changes from one role to another are not understood as role transition. Cyclical development is inherent to transition although it might be perceived as moving in and out of roles, which it is often understood as a linear process. The time frame for

transition is usually brief although this may not be the perception of the person who is experiencing it.

Rossi (1968) presented a structural analysis on transition to parenthood based on her research. In her explanations she parallels the process of becoming a mother with becoming a parent. Four cyclical stages are described. Firstly, the 'anticipatory stage' is a pre-conditional stage, which facilitates role adjustment. Socialisation during childhood and early adulthood form the 'person to be'. The better this preparation, the easier the transition into a new role. Secondly, following childbirth is the 'honeymoon stage'. This phase can be called a 'psychic honeymoon' in which close intimacy initiates and supports the bonding process. This stage involves a vast amount of learning as well as testing one's capacities and limitations. Thirdly, when a role is fully exercised a 'plateau stage' is achieved. This might be the point when maternal identity is accomplished. Fourthly, the 'disengagement-termination stage' of the maternal and parental role, is marked when the obligations of parents end. According to Rossi (1968) this happens when the child marries but a maternal and parental role never really ends.

The 'ease of transition into role' is influenced by several factors, which are described by Burr *et al.* (1979:84). This middle-range theory contains several independent variables influencing the dependent variables of ease or difficulty in accomplishing a social role. This theory adds to what is involved in the process of transition to motherhood. The independent variables are 'anticipatory socialisation', 'role strain', 'transition procedures', 'amount of normative change' and 'facilitation of goal attainment' (Burr *et al.*, 1979).

'Anticipatory socialisation' facilitates role adjustment and the better the preparation the easier transition into a new role can be accomplished. Burr and his colleagues (1979:84) define this stage as

the process of learning such phenomena as norms, values, attitudes, and subtle dimensions of a role before being in a social situation where it is appropriate actually to behave in that role.

In relation to motherhood opportunities to observe motherly behaviour are available to all women, at the very least their own experiences of being mothered as children. Other opportunities might include caring for siblings or baby-sitting, which arise

during childhood and adolescence. Women also learn theoretically how to care for a child but despite that there is a lack of real preparation. Pregnancy is the time when women can educate themselves about their role and caring for a child. However, the situation does not allow for real training. Preparation is restricted to discussions and consultation with friends, reading books or making practical preparation for the expected child. Since childbirth marks the start of the practical side of the new role with 24-hour responsibility for the dependent baby, there is no gradual introduction to it (Rossi, 1968). Despite all the mental, emotional and practical preparation for motherhood there is an abruptness to this process, which is not comparable with other transitions. Such abruptness can cause a crisis, adhering to Erikson's terminology (1968), a developmental crisis.

The term 'role strain' is used in relation to the stress that a person feels in complying with the expectations of a particular role or a role set. The level of role strain ranks from none to very high, the latter involving a high level of uneasiness and frustration in coping with the demands. Role clarity, which means having a clear picture of what the substance of a role is, influences role strain and indirectly influences the ease of taking on a role. The ease of role transition is also influenced by 'transition procedures', which are dictated by social context. Values assigned to a role by a culture designate its importance and influence the process of change. The "amount of normative change refers to the number and social significance of the norms that are changing in a person's total role set at any particular time" (Burr *et al.*, 1979:87). In taking on a new role, relevant norms change for the particular individual. The concurrence of new roles, the number of related norms and how far a person is capable of coping with them determine the ease of transition. The last of the independent variables is 'facilitation of goal attainment': the number of roles and the values a person gives them facilitate goal attainment (Burr *et al.*, 1979).

The transition from woman to mother implies changes from one state to another and development and growth is influenced by a variety of factors. The next section will introduce the definition and the process of maternal role attainment since this theory evolved within nursing.

Definition and process of maternal role attainment

Maternal role attainment is a process which occurs over time, beginning with pregnancy, with images of motherhood or with thoughts, wishes or the decision to conceive (Bergum, 1989). According to Mercer (1985) the maternal role is initiated during the woman's own experiences of being-mothered. However, the embracement of the maternal role, the achievement of a maternal identity and the time frame of this is as individual as human beings are. Maternal role attainment as defined by Mercer (1985:198) is

a process in which the mother achieves competence in the role and integrates the mothering behaviours into her established role set, so that she is comfortable with her identity as a mother.

Maternal role attainment is a learning process and is mediated by psychological understandings and interpretations of the role of mother. Rubin's work (1961) on puerperal change theory, has dominated understanding of early postpartum care and informed researchers in this field for decades (Martell, 2001). Rubin found that women experienced a 'taking-in' process from birth to the third postpartum day and a 'taking-hold' process from the third to the tenth postnatal day. In the taking-in phase women were more self-focused and passive about baby care. In the taking-hold phase women became more active in baby care and interested in learning mothering tasks. More recently, Martell (2001) has questioned the relevance of Rubin's 1961 framework to contemporary women. She interviewed women during the first week following a vaginal birth and again one to two weeks later. She found that women's postpartum psychosocial development was a continuous process without discrete stages and phases. Moreover, the results of her study focus not only on the first-time mother's new experiences but also include contextual factors and how they affect their lives. *Heading toward the new normal* is how she conceptualises the "process through which these women were reorganising their lives as mothers" (Martell, 2001:499). Rubin's and Martell's views vary in terms of a stage-wise versus a continuous process of maternal role attainment, and the time scale is variable as well. However, it appears that changes occur quite rapidly in this early phase of motherhood and the process is fluid.

Maternal role is associated with mothering a child and is culturally prescribed and formed through social interactions. Within role theory the structuralist tradition emphasises the normative element of a given social status within a culture whereas the interactionist tradition stresses the behavioural aspects “emerging out of social interaction” (Nye and Gecas, 1976:5). As nurse researchers, Rubin, and Mercer her student, view maternal role attainment prominently as an interactional process and therefore have conducted research on maternal role attainment from this perspective. Mercer (1985; 1986) and Rubin (1967a; 1967b), applied an interactionist paradigm where the mother defines and develops her role in interaction with her baby and in congruence with her self-system. This role modelling process is influenced by the mother’s beliefs and values, her past and present experiences and her social context. Internalisation of the maternal role is dynamic and proceeds over four stages, described by Thornton and Nardi (1975) as ‘anticipatory’, ‘formal’, ‘informal’ and ‘final’ or ‘personal’ stages. The expectations an individual has of the role and the reaction to those expectations are crucial in determining the internalisation.

An early study done by Rubin (1967a; 1967b) on maternal role attainment elaborated on the questions of how a particular role is acquired and what is involved in this process. Later, in her book *Maternal Identity and the Maternal Experience*, she applies the term ‘maternal identity’ (Rubin, 1984). In the process of acquiring maternal identity three dimensions are identified: ‘the self system or self concept’, ‘the process or method as mode’ as described above and ‘the model or referents’. Three interdependent categories of the self-system in maternal role-taking are ‘ideal image’, ‘self-image’ and ‘body image’. Ideal image is characterised by qualities, traits, attitudes and achievements desired for maternal behaviour. Self-image represents a consistent ‘myself’ with little sense of the historical self but describes the continuation of self into the present context. Body image, although usually not considered in role theory, is especially relevant to maternal role-taking. The way in which a woman perceives her body and its capacity to function and adapt is particularly pertinent to the process of acquiring maternal identity during pregnancy and early post-birth. Models or referents tended to be the woman’s own mother in the first instance, replaced soon by peers either within or outside the family.

The anticipatory stage, called 'mimicry' by Rubin (1967a) starts off as an active process of learning how to act and what to expect by carefully observing peers or mothers. 'Role play', the formal stage of role acquisition, is characterised by acting out the desirable behaviour and "by meeting the requirements rather than modifying them" (Thornton and Nardi, 1975:877). 'Fantasy', is concerned with the mother's imagined perception of the self and the child to be. There is no enacting of fantasy as it remains in the woman's mind. 'Introjection-projection-rejection', which can be compared with the informal stage, starts with an idea within self, reflected by a model and finally integrated into the individual experience. These phases are repetitious from pregnancy to childbirth to childrearing. 'Grief work' has to be done mainly in the latter stage of the process as the loss of former roles becomes more apparent. To achieve identity, the final stage, requires letting go of former roles, which are no longer compatible with the new role (Rubin, 1967a).

A review of the theories of transition and maternal role attainment shows Rubin's theory to be adequately differentiated and referring explicitly and solely to motherhood (Rubin, 1967a, 1967b). In her later work (1984) she presents an extended knowledge about maternal identity and the maternal experience based on large sample of women observed and listened to by nurses giving nursing care during pregnancy and the first six weeks postpartum. Authors in Nursing Science literature such as Mercer (1981; 1985), Pridham and Chang (1992), Walker and Montgomery (1994) and Rogan and her colleagues (1997) still refer to it as a classic in the field. As mentioned earlier, Martell (2001) questioned the adequacy of Rubin's theory. Nevertheless it contains every stage presented in the other theories and in more detail. Fantasy and grief work are two emphasised aspects, which do not occur as distinct stages in the transition model. The stages of identity and anticipatory socialisation appear in both approaches but Burr and his colleagues (1979) classify the latter as a factor influencing role achievement. It is not completely clear why they view a set of five influencing factors as a 'role transition theory' whereas Rossi describes stages of the transitional process. A combination of both Rossi's and Burr and his colleagues' descriptions would make a more complete theory. The last stage in Rossi's transition theory, 'disengagement and termination' is related to a familial

view which is justifiable in this context but it does not apply to the same extent in maternal role attainment.

Theories on transition and role attainment and terminology used within these theories are influenced by the scientific field in which they were developed. Experience features more strongly in the expressions used in psychological and Nursing Science than in sociological literature. In conclusion, the theories on transition and maternal role attainment describe the development as a cyclical ongoing process over time where at the end a new role or another status is achieved. Rubin's model of maternal role attainment is underpinned by an interactionist theory (Rubin, 1967a; 1967b). This emphasises the interaction between mother and baby but also the mother's understanding of herself and is important in the theory of role attainment. It refers to lived experiences of individuals whereas the transition model relates to role theory and in the literature it is made relevant for familial processes (Burr, 1972; Burr *et al.*, 1979; Rossi, 1968).

Literature reviewed thus far in the chapter has provided insight into historical dimensions of motherhood, social constructions of motherhood and the transition to motherhood. The next section will describe literature on research into achieving maternal identity. Knowledge arising from the above theories is relevant to this study as it shows the complexity inherent in and the multifaceted factors influencing this process. It adds to a better understanding of the experience of women after birth of their babies. The following discussion is relevant to the current study because it might influence health care professionals in recognising the determined factors, and encourage the support of women in their process of maternal identity attainment.

Maternal Identity

Attainment of maternal identity is a complex process “in which the mother achieves competence in the role and integrates the mothering behaviours into her role set so that she is comfortable with her identity as a mother” (Mercer, 1985:202). This process, although varying in length, is expected to last for a year post-birth but

Mercer (1985) questioned whether all women are able to internalise the maternal role within that time frame.

Adaptation to motherhood

The process of identity formation is always changing, gradually developing and extending (Rubin, 1984). To form an identity, individuals reflect on others and observe how others perceive them. This process is “‘located’ *in the core of the individual* and yet also *in the core of his communal culture*” (Erikson, 1968:22). This definition shows the psychological level of identity formation as well as the sociological level (Chodorow, 1978) in the act of an interactionist operation. The core of maternal identity dwells in the ‘I’ and ‘you’ and these concepts influence each other (Rubin, 1984). However, maternal identity is not a given and according to Rubin (1984), it is specific and personal and can only be achieved individually with each child and in relation to the child. “There is a belonging as a part to the whole personality, bound-in and inseparable...” (Rubin, 1984:38). Chodorow (1978) reasons that an orientation toward nurturing and care becomes part of women’s personalities. It can be said that maternal identity characterises the cognitive and affective maternal-infant relationship (Walker *et al.*, 1986a; 1986b). After birth the sense of unity with the child has to change to a differentiation as two separate individuals. The dyadic mother-child relationship is exclusive but there is also reciprocity with her social context, which helps by its own mean to form maternal identity (Chodorow, 1978).

Women recognise maternal identity when they are in contact with and when they have feelings for the child (Zabielski, 1994). Research into the duration of this identification process tends to focus on functional attributes and cognitive recognition of fulfilling the social role as a mother. However, feeling confident in the new role is an important attribute of maternal identity and a congruent perception of physical, emotional and social processes results in a more holistic view.

Physiologically a new mother’s body is considered to be fully recovered at six weeks post-birth, which is defined as the *postpartum*. This has informed maternity policy in

many societies over decades but this view is challenged by several studies. Similarly to Mercer (1985) Tulman *et al.* (1990) give empirical evidence that at six weeks post-birth less than 30 per cent of the 97 women in their study had assumed the functional status to perform maternal, social and self-care activities. Functional status, defined as “the woman’s readiness to assume infant care responsibilities and resume her usual activities”, improved steadily until three months postpartum (Tulman *et al.*, 1990:70). According to this group of researchers although the mother’s functional status had improved, 30 per cent had not resumed social activities and 80 per cent had not found their way back to their usual self-care activities at six months postpartum. They expressed their hope that those findings would influence social policy strategies to consider maternal or parental leave and community support service (Tulman *et al.*, 1990).

As Mercer’s (1985) and Tulman *et al.*’s studies (1990) show, the timing of when women with normal birth experiences recognise themselves as mothers is variable. The variation is even greater for mothers who deliver preterm babies (Zabielski, 1994). Data collected retrospectively in Zabielski’s exploratory and descriptive study (1994) demonstrates that women recalled an event that marked the time of identity recognition. At two weeks post-birth, 62 per cent of twenty-one full-term mothers recognised maternal identity compared with 24 per cent of 21 preterm mothers. These results show that mother-child contact influenced identity recognition.

As described earlier in this chapter multiple factors facilitate the attainment of maternal identity. Within the field of nursing Rubin and Mercer were pioneers in researching the subject with Mercer (1981) leading this type of investigation. She provided a theoretical framework describing the following variables: age, perception of birth experience, early maternal-infant separation, social stress, support system, self-concept and personality traits, maternal illness, child-rearing attitudes, infant temperament, infant illness, culture and socio-economic status. Based on that model, Mercer investigated and studied the process of maternal role attainment up to one year post-birth (Mercer, 1985; 1986). The study result indicates that health care professionals are in the position to facilitate the attainment of maternal identity. Suggestions are: to support women in their interaction with their babies, to ensure that women can rest and sleep, and to provide information and feedback to women

about their mothering behaviour (Mercer, 1985). It is also suggested that women be guided in identifying resources for support, which help them to cope with the infant-related changes in their lives, and taught about expected growth and development of their babies (Mercer, 1986). Walker *et al.* (1986a; 1986b) make use of Mercer's framework (1981) to study 64 first-time and 60 experienced mothers up to six weeks postpartum. Stability and change in women's self-confidence were significant in relation to maternal identity (Walker *et al.*, 1986a). During the early weeks post-birth first-time mothers' self-confidence was significantly correlated to mothering behaviours during feeding procedures. Walker *et al.* (1986b) propose similar ideas to Mercer: to assist women in their nurturing role, to guide them in their interaction with the baby, and to confirm them in their behaviour. In addition to the recommended care interventions and with reference to the variables identified in Mercer's theoretical framework, further suggestions might be to support women in coping with birth experience, to ensure continuous rooming-in and to associate women with the social and professional support network. However, the question remains if women can prepare themselves prenatally to facilitate growing into motherhood.

Smith (1999b) believes that pre-birth preparation contributes positively to maternal identity formation. He considers pregnancy as the time of preparation for motherhood on a physiological, psychological and social level. The body has time to adapt steadily over the nine months period and to be prepared for birth. A small number of case studies of expectant mothers reveals that "pregnancy provides the opportunity for important psychological preparation for mothering" (Smith, 1999b:422). This is a time of growing and maturing but it can comprise regressive behaviour expressed in role-play, thus progress and regression are in a dynamic relationship. Visualising the self as a mother-to-be and relating to oneself and the growing baby is important preparatory work. Moreover, the self can be shaped against the perception of past experience with and through attachment to significant others. Social identity as an expectant mother is sought by negotiating the role within the circle of family and friends. Smith (1999b:424) suggests that "pregnancy offers a particularly strong opportunity for the negotiation of identity".

The process of adaptation to motherhood is facilitated by a variety of internal and external factors which may affect how quickly this is achieved. One emphasis in research on maternal identity is functionality, which clearly gives a one-sided picture of the process. Another emphasis is on confidence growing out of the interaction with the baby. However, views on the pre-birth period are of interest to this study, which will also consider women's expectations and how they influence their perception of postnatal care.

Experiencing Motherhood

Having examined the process of becoming a mother, this section focuses on the experience of the early phase of first-time motherhood. Experience and its expression are individual. According to Rubin's theory (1984:13) of the self and the body image, "experience is mediated in the self". The perception of herself and her feelings determine her experience. Postnatally, women are particularly vulnerable (Rubin, 1975) and it is debated whether becoming a mother for the first time is a crisis event or simply a stressful episode in a woman's life as mentioned earlier in this chapter.

The profound effect the maternal role can have on women's lives is expressed in their reactions to this major life event. Oakley's work (1980) has been significant in this respect. Woman's responses to childbirth, in particular first childbirth are as she describes, akin to responses to other major life events. Women tell of enormous disruptions to lifestyles, routines and identities (Oakley, 1980). Despite the claim that experience is individual numerous studies of motherhood from women's perspectives demonstrate that the attainment of motherhood appears almost uniformly problematic for women. In more recent times an attempt has been made to conceptualise the experience of early motherhood. This proves useful for health care professionals to better understand first-time mothers and their reaction to early motherhood. However, a uniform application of theoretical assumptions might well be problematic if individual experiences and reactions are ignored. Nevertheless, such theories make an important contribution to Nursing and Midwifery and inform

practice by “effecting change in the provision of care to postpartum women and their families” (Sethi, 1995:235). The following section will introduce study findings which are particularly relevant to the early phase of new and first-time motherhood. These shed light on the complexity of the processes involved in becoming a mother.

Unifying experience

To investigate the experience of first-time motherhood a few researchers shed light on it from a phenomenological viewpoint. Bergum (1989) and Cudmore (1997) for example explore the experience of first-time motherhood using a phenomenological approach. Both studies will be introduced briefly.

Bergum (1989) initiated conversations by open-ended questions with six first-time pregnant women with almost identical backgrounds. Data collection covered the period from mid pregnancy to the end of the first postnatal month. Data revealed themes and by immersing in language and shared meaning it was possible to uncover the nature of lived experience of women becoming mothers. Bergum (1989:13) weaves the thematic moments into existential themes of ‘lived time’, ‘lived space’, ‘lived body’ and ‘lived relationship to others’. Her research substantiates the importance that experience can only be understood in the context of a woman’s life. The metaphorical journey from women to mothers elaborated in Bergum’s study (1989) is twofold: an inner journey as women develop a new self, and an outer journey involving the attainment of the new role of a mother. Nevertheless the prime focus of her study is on birth as a transformative experience.

When transformation from woman to mother begins it is individual and varies widely but childbirth symbolises this process. With the painful separation of woman and child two new selves are born although they remain a dyad. The dialectic of attachment and separation in this new relationship is apparent, two individuals form a union but they grow into an *I* and *you* (Rubin, 1984). To be a mother means responsibility and the experience of living with a child on one’s mind, which leads to changes in a woman’s understanding of herself. To recognise that she is the preserver and nourisher of the baby involves attentive love. To have a child on one’s mind

broadens the horizon. The world can be perceived differently and a shared understanding of how babies and mothers are is a unifying experience (Bergum, 1989).

“Being a mother is an experience that creates a shared landscape for all women with children” (Cudmore, 1997:93). Similarly to Bergum (1989) Cudmore tunes into this unifying experience. Such an understanding acknowledges the uniqueness of women as mothers and reveals a spiritual dimension of motherhood. However, from the familial point of view, partners and other family members are excluded in such an notion. Factually, Cudmore (1997) explores what it is like to live in the world as a new mother and does not inquire into the wider social context of women. Her findings give evidence of the transformative experience of four new and first-time mothers retrospectively. Women were recruited prenatally and asked to write answers to two open-ended questions three months after birth. Subsequently they took part in an individual interview based on themes that had emerged from the written accounts. Retrospective accounts entail the hazard of losing the thread of reality and recounting the most distinct experiences. In contrast, Bergum’s prospective study (1989) follows women through their transition process and strengthens the outcome by capturing experiences as they occur. Nevertheless Cudmore’s analysis (1997), which follows a psychological phenomenological method reveals three central dimensions. Firstly, “experiencing a profoundly close and loving relationship with one’s baby; secondly, living with one’s baby as an enduring presence and thirdly, experiencing an expanding horizon of interrelatedness” (Cudmore, 1997:95).

Bergum (1989) and Cudmore (1997) investigate the phenomenon of living in this world as a mother. Knowledge derived from these two studies helps to deepen our understanding of the lived world of new mothers.

Focusing on the inner and outer world

Smith’s study (1999a) focuses on identity development during pregnancy and how it affects life after birth. The results are informative and reveal the complex nature of

the transformative experience. What is shown clearly is that the process of becoming a mother starts long before birth. When describing their journey women reflect their experiences of their inner and outer world.

As noted earlier in this chapter, transition to motherhood is of widespread interest to researchers from divergent disciplines. Smith (1999a:281), a psychologist, developed a “theoretical model of how aspects of woman’s sense of identity can be transformed during the transition to motherhood”. The design of this study is a complex one which Smith describes as an “idiographic, phenomenological, grounded theory approach” (Smith, 1999a:296). Four first-time mothers took part in the study and they were each visited four times; at three, six, and nine months of pregnancy and five months after the birth of the baby. Interviews were conducted at each visit and the women kept a diary for the whole period. In addition, on each visit Smith (1999a:285) used repertory grids, “a method for tapping into the way an individual perceives his/her personal and social world”. He then used the data from these three sources to develop what he called case studies for each woman. These case-studies formed a data set for identification of key components across cases. Patterns were identified from the data and then a theoretical model was developed based on them. While Smith’s research design (1999a) may be somewhat atypical and based on data from a small sample, the model he developed is useful in examining the complex nature of the transformative experience of becoming a mother.

The key findings of this study are that during pregnancy there is a shift in a woman’s perception of her social roles away from the public world of work to the more private world of family and friends. Concepts identified during the process of pregnancy were at three months, adjustment and uncertainty because of lack of physical evidence; at six months, changing self-perception and psychological preparation for mothering; at nine months, turning towards the impending event of birth. Pregnancy was found to be perceived as a preparatory phase to reassess work involvement and to establish a life in which family has priority (Smith, 1999a). Throughout the process of pregnancy women were primarily challenged on the emotional and physical levels but five months after birth they were reviewing their priorities and life options. These results could inform antenatal education of expectant mothers by emphasising the high demands of adjustment throughout the process of pregnancy

and post-birth. In the next study introduced adjustment is one of the major concepts considered during the early postnatal phase.

Adjustment and change

An American nursing study of postpartum adjustment of low-risk women identifies that postpartum is a time of adjustment and change (Ruchala and Halstead, 1994). The study deals with women who experienced a shorter hospital stay than the women in the current study and the focus is on the early postnatal experiences. It therefore provides an overview of factors that may influence a new mother's behaviour in that early postnatal phase. Fifty women participated in this study, they were Caucasian and African-American, middle and upper class, and equally divided between first-time and experienced mothers. They were interviewed in their homes within two weeks of discharge. Areas of concern covered during the semi-structured interview included "feelings and concerns about postpartum experience and support systems and resources used by the mother after discharge" (Ruchala and Halstead, 1994:85).

The authors indicate that Bandura's theory of self-efficacy guided the study. This is useful in the context of the current study because, according to Bandura, it is possible to understand whether people will attempt to cope with difficult situations based on an understanding of how they feel about their effectiveness. The theoretical framework guided the interviewers in their conversations with the women, which were approximately 30 minutes long. Nine categories emerged from the data, which were predominantly experiences of negative feelings and concerns. This negativity might have been due to the fact that highly emotional subjects were considered in a very short time frame. Nevertheless giving birth to a child and being a mother was also described as enjoyable, so impressions of postnatal experiences were not solely negative. Ruchala and Halstead's report (1994) does not separate the first-time mothers' experiences from the experienced mothers. To the benefit to the current study, findings from first-time mothers are extracted wherever possible.

In the above mentioned study, fatigue featured strongly and it influenced women's relationships with their babies and their partners. It also affected the daily conduct of

their tasks. Pain, uncomfortable feelings about their bodies and sexual relationships were concerns women expressed. Significant was the fact that physical discomfort and early discharge from hospital were felt to be responsible for lack of rest and recuperation. Women felt emotionally down, tense, irritable or depressed. Crying helped to release stress and to express those overwhelming feelings. Rationalising what had happened was another way of coping for those women. Some women felt isolated and excluded from their social lives, and it was of prime importance to most to have someone close around. This person might also serve as a role model and was most often their own mother. The baby's behaviour was a contributing factor to how satisfied and confident women felt. Mothers in Ruchala & Halstead's study (1994) referred to their babies as 'good' or 'difficult'. The researchers conclude that first-time mothers obviously lack experience with infants and knowledge about infant care. More important is their apparent underestimation of the time and work involved and what it means to be responsible for their babies. This leads to claims that hospital stays are too short to educate women adequately and that follow-up programmes are insufficient for low-risk mothers.

The time horizon of Ruchala and Halstead's study (1994) determines the immediacy of physical, emotional and social experiences which are relevant to postnatal care. The next two studies introduced cover a wider time frame, hence the outcomes reach beyond Ruchala and Halstead's.

Conceptualising the experience of early motherhood

Grounded theory studies of the experience of early motherhood have been completed by Sethi (1995) in Canada and by Barclay and her colleagues (Barclay *et al.*, 1997) in Australia. Since both studies illuminate the process of becoming a mother, they are helpful in enabling nurses and midwives to develop strategies for providing care for women and will therefore be discussed in some detail. This applies in particular to Barclay and her colleagues' (1997) study as this theory guides the analysis of the current study.

The Dialectic in Becoming a Mother was the basic social psychological process that arose from Sethi's study (1995:237) of twelve first-time and three experienced mothers. Women who participated in the study were, with one exception, Caucasian, of varied socio-economic status and living with the father of the baby. Interviews at two to three and ten to twelve weeks after birth and four narratives from non-fictional literature comprised data for the study. Diversity of the sample is considered a strength in grounded theory. However, the demographic background of the women studied was rather homogenous.

'Dialectic' is a term usually associated with philosophical discussions and Sethi (1995) uses it to describe how reality is in a process of constant change and transformation. In the postnatal period the transformation occurring in a woman results from new understandings of the phenomenon of post-birth. Sethi developed four categories as well as subcategories relating to the core category of the dialectic. She claims that these subcategories were necessary to capture the multidimensional aspects of the processes involved in the transformation. These categories, which are distinct but not mutually exclusive, include 'giving of self', 'redefining self', 'redefining relationships' and 'redefining professional goals' (Sethi, 1995).

Within the category of 'giving of self' there is tension between attending lovingly to, and doing everything for the newborn baby, and feelings of loss, frustration, discomfort and uncertainty. 'Redefining self', involves a dialectic between ambivalent feelings and re-evaluation of the self which is in tension with discovering new aspects of self and transforming into a new identity. In the next category, 'redefining relationships', three dimensions of the self become apparent: the relationship partner, the sexual partner and the co-parent. Tension lies between the uniqueness of motherhood and family and the loss of shared time in a relationship. In the last category, which is 'redefining professional goals', growing into motherhood and feeling confident are in tension with losing the known self and concerns about childcare and finances.

The complexity of becoming a mother, resulting from constantly redefining the self, is made transparent in Sethi's conceptualisation (1995) of the experience of first-time motherhood. The tension between opposing experiences and the spiral-like process

of developing a new identity add to the complexity. Therefore this conceptualisation sheds light on the differing but interrelated processes that occur during the first three months of motherhood. It becomes obvious that postnatal care entails a lot more than physiological aspects and standardised care alone would not suffice. Individualised care is one of Sethi's recommendations. Her statement that "the processes of becoming a new mother extend far beyond the conventional six-week period after the birth of an infant" (Sethi, 1995:243) is in tune with other authors and relevant for health care policy. This needs to be taken into account in any changes occurring in postnatal care provision. Supportive care programmes as Sethi (1995) further recommends need at least to be ensured up to three months post-birth.

Barclay *et al.* (1997) and Rogan *et al.* (1997) have published two articles outlining the findings of their grounded theory of early motherhood. The aim was to understand the processes by which low-risk first-time mothers take on their maternal role. In their study of 55 women, 'becoming a mother' was the basic social process or core category. Unlike in Sethi's study (1995), the sample existed solely of first-time mothers but the women participating in the Australian study were also from varied socio-economic status and living with the father of the baby. Data were collected through focus group discussions which were conducted with women attending Early Childhood Centres. The time of data collection ranged from two to twenty-six weeks postnatal, which exceeds the time scale of Sethi's study and therefore contributes to knowledge beyond the three-month period post-birth.

The evolution experienced by the women is from an initial phase, described as "this isn't my life anymore", to a state identified as being "in a certain tune" with the baby. Barclay *et al.* (1997) and Rogan *et al.* (1997) found that becoming a mother involves six categories: 'realising', 'unready', 'drained', 'loss', 'aleness' and 'working it out'. All categories are closely linked to each other and not distinct phases. In the following sections, I describe the six categories separately as they were developed by these Australian researchers.

'Realising', the first category, describes the overwhelming process of becoming a mother and the impact the birth of their child has. Inherent is the recognition that "this is my baby and I have to care for it" (Rogan *et al.*, 1997:881). Realising is

multifaceted as it embraces orientation of the self within the experience. It is influenced by the expectations women have, their birth experience and the amount that has to be learned with a baby. At the time of discharge realisation becomes even more apparent as the women realise what their responsibilities are.

‘Unready’ is a state dependent on how women have been able to face the reality of new motherhood. This describes the experience women have during pregnancy and early motherhood. This sense of overwhelming change occurs over time and when new challenges feature. There is a limit to how well a woman can prepare for life with a child but emotional, physical and practical preparation for birth and parenting helps to tune in. Prenatally, women expressed fears but also hope for change and wondered if they would be ready when the time came.

The third category, ‘drained’, describes a sense of having given everything and of being emptied out. Feeling exhausted and overwhelmed from birth and from the experience of having a baby, uncertain in their identity, lacking sleep and being aware of the amount needing to be learned results in tiredness, which makes new mothers less able to interact with others, to seek assistance or to have time out for themselves.

‘Loss’ the fourth category features pragmatically but entails fundamental aspects of life. The entrance into a new role involves facing another as yet unknown self, and a corresponding loss of the previous way of life and its rewarding social roles. Nonetheless loss is accompanied by the gains of the joyful experience of having a baby and being a mother. With the baby growing older and the mothers’ gaining confidence in their abilities, these gains become even more apparent.

Being a mother entails times of being alone with the baby, which is expressed in the fifth category: ‘aloneness’. Going home can be shocking after having felt able to cope with the baby during the time in hospital. The isolation women feel with a baby is characterised by lack of support and anxiety. Aloneness also has a positive aspect since women are able to care for the baby and themselves in their own way. Support from partners was found to increase confidence, but if there was a lack of support from partners, women felt guilty demanding it. Sharing the reality of motherhood with other women was perceived as helpful.

‘Working it out’ is the sixth and last category in this journey of early motherhood and it describes the development of skills and confidence as mothers. To face the challenge means making the necessary adjustments and incorporating the baby into life. This means that women have to trust their own judgments and feelings, thus helping them to become independent from professional opinion and advice.

The six categories are set alongside the storyline beginning with ‘this isn’t my life anymore’ to ‘being in a certain tune’. The entry point marks the realisation of motherhood whereas at the end a sense of synchronicity with the baby and a sense of self as a mother have been developed. Mediating factors which facilitate growing into motherhood are: the nature of the baby and how the baby reacts to the mother’s behaviour, prior experiences with babies and the nature of social support available to women.

The above described categories are informative for health professionals in the postnatal care field. Similarly relevant are the mediating factors affecting mothers’ requirements in terms of postnatal care provision in hospital and in the community. Additionally, those factors influencing the experience of becoming a mother were recognised as being important in developing strategies for family health care provision (Barclay *et al.*, 1997; Rogan *et al.*, 1997). While the use of focus groups might be questioned for discussing intensely personal experiences, the synergism of a group can also be reinforced by the effectiveness of discussions like those in this study, which raise issues and facilitate discussion (Watts and Ebbutt, 1987). Also the similarity of the findings of this study with others on early mothering experiences indicates that focus group discussions did not appear to inhibit women’s discussions.

The two grounded-theory studies by Sethi (1995) and Barclay *et al.* (1997) are in agreement with Bergum’s phenomenological study (1989), discussed previously. In the three studies, the transition to motherhood, though temporally linear is viewed as cyclical, and as a developmental progression, irregular and uneven. This transformation involves depth, complexity and dramatic change. The different phases are intertwined and present experiences that can reach back to the past can be presented differently and brought forward with new significance.

As has been shown, the experience of motherhood is a complex one, and contrary to popular myth, is not purely an enjoyable experience. The various studies discussed in this chapter have used different methodologies and theoretical perspectives to examine the experience of becoming and being a mother and therefore enrich the insight into the experiences of new mothers. They give insight into what living in this world as a mother means, and show that there is an inner and an outer world relevant for women to transform them into mothers. There appears to be adjustment, change and re-organisation, which affects women at the physical, emotional and social levels of life. This has been shown in all the studies introduced in the section 'Experiencing Motherhood'. The time of adjustment is viewed as highly vulnerable and reality-testing. The amount of change involved is challenging for mothers and for their social network. A total reconstruction of a woman's life becomes apparent with a child. It is not only an external reorganisation. It affects the whole being of a woman as expressed in the statement made by so many women: 'life will never be the same again'.

Summary

In this chapter I have shown that the complexity associated with the concept of motherhood occurs at both societal and individual levels. Looking at motherhood from a historical perspective demonstrates that the ideology of motherhood has changed from focusing on childbearing to serve the society, to personal fulfilment. Becoming a mother nowadays is a personal choice as much as remaining in the work force has become the norm for many women. The impact of social factors in constructing motherhood determines the role of mothers and it highlights the need to take these factors into consideration in the present study. The transition to motherhood is a process that progresses in stages which are neither smooth nor gradual and it entails enormous adjustments and changes in a woman's life. These adaptation processes appear to be demanding and leave women very vulnerable. Literature reviewed on the experience of new motherhood enriches the understanding of this multifaceted and individual development. Attempts to conceptualise the

experience of this journey from woman to mother have drawn attention to the spiralling and complex nature of this trajectory. It is therefore timely to include an examination of contemporary women's understanding of the impact of their experiences of becoming mothers, as this study does. Maternal identity formation is a process that extends over a long period exceeding the time before and after birth by far. Studies reviewed on that subject are informative and knowledge gained contributes to the understanding of the complex nature of maternal identity.

The literature introduced in this chapter is highly valuable in informing midwifery and nursing practice about the construction of motherhood and women's experience, hence it shows the importance of taking these into consideration when working with first-time mothers. However, there are some weak points in the existing literature. Some studies, though considered relevant for an informed understanding of the subject, include only a small number of women. Hence, generalised conclusions cannot be drawn from those studies. The same applies to the current study. Nevertheless researching experiences and observing realities are best done by a qualitative research approach, which limits the number of participants because of the time-intensive research procedure. A further problem is that the socio-cultural background of women researched is widely uniform and minority groups are rarely involved. In the current study the sample is equally uniform, and the same critique applies. Another weak point is that most information in the studies introduced was obtained by interviewing women retrospectively. While this seems appropriate in some studies there is a consequent lack of knowledge of how care provided by nurses respond to new mothers' experiences during the early days post-birth. Therefore questions surround what first-time mothers' expectations are, and what they experience while they are in the postnatal care setting.

In consideration of the literature reviewed, the current study takes into account the phenomenon of transition from woman to mother, and postnatal care provision in response to that at the early stage post-birth. Against this background, the literature of relevance to the analysis of the provision of care and support for new mothers in response to their experience during the early postnatal phase is now reviewed.

CHAPTER TWO

CARE AND SUPPORT IN THE EARLY POSTNATAL PHASE

Introduction

The review of the literature in the previous chapter demonstrated the complexity of the construct of motherhood, how the transition is experienced by women and the diverse aspects influencing this process. On the journey to motherhood women are in a highly vulnerable situation and this vulnerability finds expression in various forms, which all influence the transition. Such experiences need a sensitive response from professionals which take into consideration women's individual backgrounds, as well as their physical and emotional conditions. Therefore, midwifery as a profession is arguing for a women-centred approach (Harcombe, 1999) to meet satisfactorily the needs of new mothers. Conversely, professional conduct is guided by various institutional factors and the personal attitudes of health care professionals, who are members of society and as such influenced by popular notions of motherhood. Such a construct challenges health care professionals to adapt constantly their care response to the changing conditions of new mothers. In the present chapter, literature relevant to the exploration of care and support in the early postnatal phase is appraised. This chapter is set out in four sections.

The review in this chapter starts with a synopsis of postnatal care, how it is organised and what appreciation it receives from professionals and the public. Principles of postnatal care are presented from the professional's point of view and issues of quality care are discussed from the perspective of the recipients. The second section is devoted to the needs of new mothers in relation to hospital-based care and to how professionals perceive those needs. An outline of the relevant literature on care and

support is included to explain the distinction between the two terms and to show how the two concepts are nevertheless interrelated. The last section is concerned with the introduction of Swanson's conceptualisation of caring (1991; 1993). This framework is presented as informing knowledge, as it is essential to analyse postnatal care within an understanding of caring. The chapter ends with a summary of the literature review and the rationale for the study. This literature review will shed light on postnatal care in general with an emphasis on hospital-based postnatal care.

Postnatal Care

Issues of postnatal care are widely addressed within maternity care literature, either from the women's or the health care professional's perspective. Despite that recognition, pregnancy and birth issues have attracted far more attention in the literature and this might mirror the interest of professionals in these segments of maternity care. However, this study focuses on postnatal care and therefore it is the aim of this section to give an overview of important aspects of postnatal care and the nature of care provision during the early phase post-birth. Postnatal care organisation and professionals responsible for its provision varies across Western European countries. Since this study took place in Switzerland, a brief introduction of different systems of postnatal care provision is appropriate here.

Organisation of postnatal care

Looking across Western Europe, the literature reveals that postnatal care is provided by various groups of professionals. For example in the UK, Sweden and Norway, midwives provide postnatal care. In the Netherlands, maternity care assistants are the primary caregivers after discharge, whereas in Finland, a mixed group of public health nurses and midwives are responsible for postnatal care (Expert Group on Acute Maternity Services, 2002a, b). In Germany (Hasseler, 2002) and in Switzerland as described in more detail in Chapter Four, it is more common that registered general nurses and children's nurses are involved in postnatal care,

whereas antenatal and perinatal care is provided by midwives. This indicates inconsistency of carers during women's maternity, which is recognised as a factor in depleting quality of care (Longworth *et al.*, 2001) and is one aspect of fragmentation of care provision. Traditional care provision in postnatal settings separates tasks into those for mothers and those for babies, although mother and baby are together, known as 'rooming-in' practice. This results in a registered general nurse caring for the mother, while a children's nurse caring for the baby. This division of care provision was rooted in the belief that nurses would pass on infections to the babies. This goes back to the time of infectious diseases and high rates of maternal and infant mortality. Although maternal and child death rates have been brought under control, and attempts have been made to improve quality care, this approach can still be found in German hospitals (Hasseler, 2002).

Postnatal care organisation has undergone tremendous changes since the early discharge policy moved this care segment to the home and hence to the community setting. Since birth predominantly takes place in hospitals, that is where postnatal care starts. However, it is relevant to mention that preparation for postnatal care starts before birth with antenatal classes or other preparatory tasks. Postnatally, new mothers depend on care provided by professionals regardless of whether they are in hospital or at home. However, this varies according to individual needs.

The period after birth is known as the *puerperium* and is defined as "the time from immediately after the end of labour until the reproductive organs have returned as near as possible to their pre-gravid condition, a period of six to eight weeks" (Sweet, 1997:472). As shown in the previous chapter, this time frame does not suffice for all women to adapt to motherhood, to fully recover physically and to reach a sufficient functional status necessary for engaging in social activities. Hence, for many women the time needed for postnatal care would exceed the defined time of the puerperium. Schemes of maternity leave provision as in place in Western European countries might help to overcome financial constraints but these do not compensate for the physical and emotional recovery postnatally. However, postnatal care provision is limited. Taking the UK as an example, midwives are the professional group responsible for it up to the maximum of twenty-eight days post-birth (UKCC, 1998). The focus of postnatal care is "to help the mother adapt and successfully fulfil the

role and responsibilities of motherhood” (Sweet, 1997:472). Furthermore, postnatal care is defined as:

Provision of appropriate emotional, psychological and educational support which should be tailored to meet the particular needs of each mother. Such support and a facilitative style of parent education helps to build up the woman’s confidence in her mothering ability, especially in the key areas of developing a relationship with her baby and establishing successful feeding. (Sweet, 1997:472)

As shown above, postnatal care is provided by diverse groups of professionals. Nurses with a general or a specialised professional background and midwives are recognised as the main professionals providing maternity care in Western European countries. General Practitioners and Medical Specialists participate according to national policies. Considering postnatal care Ball states:

No single group of professionals has the monopoly of concern for the welfare of mothers and babies nor does any group possess all the skills and attributes needed to help women from many different backgrounds and with varying degrees of maturity to realise their full potential as mothers. (Ball, 1987:150)

This declaration suggests that maternity care benefits from a mix of professionals and their specific areas of expertise. However, the WHO definition of a midwife acknowledged by the Nursing and Midwifery Council in the UK includes all three segments of maternity care:

A midwife is a person who, having been regularly admitted to an educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

She must be able to give the necessary supervision, care and advice to women during pregnancy, labour and the postpartum period, to conduct deliveries on her own responsibility and to care for the newborn and the infant. This care includes preventative measures, the detection of abnormal conditions in mother and child, the procurement of medical assistance and the execution of emergency measures in the absence of medical help. She has an important task in health counselling and education, not only for women, but also within the community. The work should involve antenatal education and preparation for parenthood and extends to certain areas of gynaecology, family planning and child care. She may practise in hospitals, clinics, health units, domiciliary conditions or any other service. (WHO, 1992)

The above definition was the basis for the definition of midwifery adopted by the Swiss Association of Midwives¹. This would suggest that in Switzerland postnatal care was mainly provided by midwives. However, changes have occurred and

¹ Schweizerischer Hebammenverband

according to Güntert *et al.* (1993) a shortage of practising midwives in the German speaking part of Switzerland made those necessary. This included the provision of postnatal care by nurses of different qualifications. In fact, at that time midwives had already been withdrawn largely from the postnatal care units in general hospitals. This meant that postnatal care units were mainly staffed by nurses. Weiss (1999) queries if this was a result of low prestige associated with the midwifery profession and less to do with the shortage of midwives. Such a division of labour policy contributes to conflicts between the two professional groups in postnatal care provision since, according to the definition of midwifery, all aspects of care during the childbearing process is to be covered by midwives.

Additionally, changes concerning postnatal care during the last few decades show a particular decline in the length of hospital stay, mainly driven by economic policy. A further change was that women are offered to choose the setting in which they would like to give birth. Unfortunately this only applies to a small percentage of women since many depend on geographical, traditional or financial factors in choosing where to give birth. This is reflected in the numbers of home birth in Western European countries. Taking Switzerland and the UK as examples, one to two per cent respectively of women give birth at home (Ackermann-Lieblich *et al.*, 1996; RCM, 2004). The Netherlands, with a rate of 33 per cent home-birth (Expert Group on Acute Maternity Services, 2002b), is the exception.

Another proposed change was that midwives and nurses should alter the focus of care from a biomedical to a more holistic approach. This indicates a development towards a more independent professional practice and a move away from medically influenced thinking. However cultural changes are problematic and take time. Arriving at a more holistic care approach is challenging with the many professional groups involved.

It can be seen that maternity services have undergone considerable changes. Postnatal care in particular faces a huge challenge. There is pressure to adopt a policy driven by economic factors, and at the same time it is still struggling to counter traditional views of it as a low-status work. Professional groups involved in postnatal care have changed their attitudes towards this segment of care due to socio-economic

circumstances. How postnatal care is received within designated professional groups and the society is outlined in the following section.

Appreciation of postnatal care

Postnatal care, although an important segment of maternity care, seems to have lost its attraction to midwives. However, what emerges from the literature is that postnatal care has always been of importance to midwives and in that respect Kirkham (1986:45) claims “postnatal care is very much the midwife’s field”. The definition of midwifery includes postnatal care, as do education programmes and textbooks for midwives (Bennett and Brown, 1989; Sweet and Mayes, 1997). Researchers such as Laryea (1980; 1984), Ball (1989) and Barclay and her colleagues (1997) have done important work in the postnatal care field. Their contribution to professional knowledge has been well received. More recently, Hasseler (2002) published her study, *Holistic postpartum care?: An evaluation of varied in-patient caring approaches in postpartum care*². Although not yet recognised widely, this study makes an important contribution to nursing and midwifery knowledge in the German speaking countries. I will refer again to this publication later and in more detail.

Despite the emphasised importance of postnatal care to midwives, there seems to be some ignorance surrounding this segment of maternity care. However, the reasons for this are difficult to discover in midwifery literature but more research has been done on care during pregnancy and labour (Murphy-Black, 1994; Podkolinski, 1998). Rooks (1999) introduces a midwifery model of care, which is specifically designed for pregnancy and birth but women post-birth are not addressed. This fragmentation on a theoretical level leads to the belief that midwifery values pregnancy and childbirth more highly than postnatal care. Hillan (1992) reports that postnatal care was the area within maternity care most frequently criticised by the women in her study. Such criticism harms the postnatal care area which is already of low priority to midwives. Güntert *et al.* (1993) take the pragmatic view that a shortage of midwives

² „Ganzheitliche Wochenpflege? Eine Evaluation verschiedener stationärer Betreuungsformen in der postpartalen Phase.“

can be made responsible for the dismissive attitudes towards this area, but as Weiss (1999) argues, low prestige from society has also placed postnatal care in an undervalued position. Maternity care went through a phase of geographical isolation at the time when unmanageable infections were threatening the lives of mother and child (Martell, 1999). Bondas-Salonen (1998b) argues that postnatal care is neither dramatic nor technologically challenging and does not have the attraction of the much more exciting phase of birth. This could be another factor contributing to professionals' lack of interest in this care area. There is also an expectation by midwives that the adaptation to this new life situation is to be seen as a normal process. Consequently and as Laryea (1984) reasons it does not need the same attention as pregnancy and birth.

By the time the reproductive process had been medicalised, as discussed in the preceding chapter, childbearing has also been hospitalised. According to Kirkham (1986), hospitalisation of a social process implies passivity of the receiver. This is not reconcilable with taking on the responsibility and self-reliance that is to be expected from women who become new mothers. It could be argued that women's self-administering care of a baby with no reliance on time and routine is in contradiction to the applied hospital routines. Consequently, midwives who prefer to work in partnership with women (Calvert, 2002) might have lost interest in this area of care.

Indeed women's appreciation of the postnatal period results to an extent from what they perceive to be emphasised by professionals. In antenatal classes, where women are taught by professionals about issues related to childbearing, the focus is on labour and birth. Midwives argue women have more interest in these areas and they would not engage as strongly with postnatal care issues as with issues about pregnancy and birth in these classes. In that respect Moran *et al.* (1997) argue that information given prenatally in relation to postnatal care is incomplete. How postnatal care is received within professional groups and by society is a result of socially determined attributes. Consequently, this influences postnatal care at large and determines the satisfaction both of professionals and women.

Construction of postnatal care

Birth is regarded as a significant social event, which is constructed by each society according to the values and ideologies inherent in their culture. How a society organises issues of childbearing says much about the value it places on reproduction and new life (Jordan, 1978). Jordan (1978) and Rubin (1975) state that the transition into safe and secure motherhood and parenthood ought to be a priority in a society. Jordan (1978) studied birth in four cultures and concludes that a change towards a holistic framework must be made in childbearing. Postnatal care from a holistic perspective “attempts to integrate body, mind and spirit” (Edwards, 2000:68). Paavilainen and Astedt-Kurki (1997) include the social network as they consider women’s experiences and their physical, emotional, social and spiritual needs from within their families. Focussing on a social unit’s experiences and needs implies turning away from the task orientation and routine which interfere with a humanistic care practice (Woodward, 1998). Considering the social network, integrating their experiences and needs would comply with a family-centred care approach. Martell and Imle (1996) introduce a childbearing family nursing approach with the aim of promoting the health of the family. The proposed theory is a blend of structural-functional, family system and developmental theories. It is important to take all members of the childbearing family into consideration and “focus on families who are healthy, as well as those who experience threats to health during the childbearing cycle” (Martell and Imle, 1996:233). Within such a holistic approach to caring, women are challenged to identify their needs whereas the professions involved are challenged to reorganise and rethink maternity service successfully which indicates a shift in positional and expert power. However, such a move involves stepping out of the medically dominated sphere of maternity care.

Cultural changes need time to evolve. Postnatal care has not yet achieved the status aimed for despite the fight for a liberating development. Hasseler (2002) carried out an evaluation study of the approach to care in three maternity hospitals in Northern Germany. The aim of this comparative study was to evaluate the effectiveness of the service of three maternity hospitals with differing caring approaches (Hasseler, 2002). Two hospitals followed a holistic care approach where mother and baby were

seen as a dyad and cared for by the same health care professionals. The third hospital offered a traditional caring approach, fragmented into provision of the mother's and the baby's care by different professional groups. Data were obtained through participant observation, care documentation, interviews with women (n=6 per hospital) during their hospital stay and again six to eight weeks after birth. In addition twenty-nine nurses and a panel of professional experts in postnatal care were interviewed.

She found that the medical model informs nursing by focusing mainly on physical care aspects and relying on assumptions rather than on evidence. She indicates the importance of a theoretical foundation for informing postnatal care and enlightening the field. Very similar conclusions are drawn from an earlier qualitative study carried out by Lind-Keel (1993) in a similar cultural context to the one under investigation in this thesis. Nothing is revealed about the sample size and the method of analysis but the aims of this investigation were to capture new first-time mothers' experiences and how they perceived nursing care. Lind-Keel (1993) deduces from her findings that care during this early phase post-birth is complex and challenging. Women in her study valued independence but simultaneously demanded that nurses took over child caring tasks on their behalf. However, the focus was strongly on women's physical well-being, adhering to the medical model. She doubts nurses were aware of the complexity of issues occurring in this new life situation to integrate and respond to experiences on all levels and if they had the knowledge required to provide adequate care (Lind-Keel, 1993).

Changes in the demographic structure of Western countries have an effect on young people's experiences of parenthood and childcare (Hasseler, 2002). The fact that new families receive less and less support from their close social network (Murphy-Black, 1994) demands that they look for different resources. In addition governments are required to develop new or different support structures. Hasseler (2001) indicates a tendency in Germany for middle-class women to leave the hospital earlier as they are in a position to organise support independently, whereas lower-class women stay in hospital longer. Whether this is a resource-related effect or an attitude born out of receiver orientation is a question of debate. Professional support post-discharge depends on how a society promotes and structures such support. Beck and Knoth

(2003) argue that in Switzerland provision of post-hospital care lacks the formal structure necessary for supporting new mothers and families at home satisfactorily. Community care programmes for new mothers are in place in several Western European countries, for example in the UK and Finland whereas in others follow-up programmes have not been established to the satisfaction of the care receivers.

Until 1986, in the UK, it was mandatory for midwives to visit new mothers at home postnatally. With the publication of the *Midwives code of practice* by the NMC the regulation changed. In the current issue of the *Midwives rules and code of practice*, activities of postnatal care feature but no directives are given in terms of frequency of postnatal home visits (UKCC, 1998). Although frequencies and the number of home visits are no longer tightly regulated, Hamilton (1998) assumes that this changing practice has been strongly influenced by managerial factors. Decisions for reducing support were possibly based on how midwives interpreted women's needs, which might well imply professional autonomy. The current practice in Scotland, based on personal communication, is that midwives attend to new mothers up to day ten post-birth. After that health visitors take over the responsibility.

Having given a brief insight into the organisational structure of postnatal care I shall now turn to the key principles of postnatal care and further examine quality care measures.

Principles of postnatal care

The Changing Childbirth Initiative was launched in 1993 in the UK by the Department of Health and adopted as government policy in 1994. The aim was to achieve a women-centred service. It aimed to make maternity service “readily accessible, responsive and effective and should involve women in planning” (Hicks *et al.*, 2003:618). The key principles of this service were: choice, control and continuity of carer throughout maternity (Pope *et al.*, 2001). Bearing in mind the definition of postnatal care mentioned earlier in this chapter, it needs to be asked if the health care structure, professionals' competence and availability can guarantee such a standard of care provision. In this respect MacArthur (1999) states:

The content of midwifery postnatal care is largely unspecified but has traditionally been based on routine observations and examinations, more appropriate to the days when it originated and when serious maternal infection was prevalent (MacArthur, 1999:343).

Physical aspects during postnatal care are unquestionably of importance for mother and baby as emphasised by Laryea (1984), but she complements these with the aspect of emotional recovery of the mother. Cudmore (1997) is equally balanced in terms of emotional and physical care:

Taking time for the new mother, to alleviate her physical and/or psychological discomfort, to answer her questions and allay her fears, is a crucial step for those involved in her postpartum care. It is only when she is no longer distracted by her own concerns that a new mother is free to open herself and be present to her new baby (Cudmore, 1997:108).

This quote stresses women-centeredness whereas Ball (1987) brings the aspect of family into play but only considered as part of a woman's network:

Providing the psychological support required to strengthen the mother's confidence in herself, and in her ability to care for their baby, whatever her particular personal, family or social situation may be (Ball, 1987:129).

Tarkka and Paunonen (1996b), two Finnish nurse researchers, specified aims based on data from first-time mothers in terms of woman and family welfare. Their study will be introduced later in this chapter. Those aims were "to support and to encourage mothers in childcare and the various matters that are related to the mother's and whole family's welfare after childbirth" (Tarkka and Paunonen, 1996b:1205). Sharing the new life situation and enabling the woman "to be in peace and quiet with her baby and her family" were focal points concluded in Bondas-Salonen's phenomenological study (1998b:171) on new mothers' experiences of postpartum care. An additional and more specific point is brought in by Fichardt *et al.* (1994), that of teaching the parents. This has become essential since early discharge policies were implemented.

Physical and emotional well-being for mother and baby is emphasised in postnatal care. Women-centeredness has become predominant, while the familial network scarcely features. However, there are considerable doubts about the capability of professionals to meet the aims of postnatal care within the ideological and structural circumstances of hospital-based care. Such claims lead to the question of how and to

what extent hospital-based postnatal care is influenced by organisational circumstances and how those affect the quality of care provision.

Quality of postnatal care

Quality of care provision has become of considerable interest within a holistic care framework and the identification of women's needs has motivated several investigations (Fraser, 1999; Hasseler, 2002; Hillan, 1992; Shields *et al.*, 1997). Despite research, quality assurance and audits, there are still complaints from women about insufficient services (Shields *et al.*, 1997). A need for improved care tailored to women's individual needs should be based on a broad understanding of each individual woman's background considering the changes in social structures. Shields and her colleagues (1997) recommend midwife-managed care as beneficial for a better outcome of psychosocial aspects of motherhood. Such attempts are coming increasingly under pressure through economic constraints, staff shortages and consumer orientation. It is therefore important to audit care provision based on approved quality criteria to influence policy.

One example of a model of evaluating quality care consisting of three categories of criteria: care resources; process and outcome is provided by Attree (2001b). Continuity of care and carers in maternity service are easily identifiable with the help of those categories. Fenwick (1998) studied the advantages of continuity for women and professionals. She found that provision of care from one or only a few health care professionals throughout pregnancy, birth and the postnatal period can lead to the formation of a trusting relationship, contributes to job satisfaction and influences the outcome positively (Fenwick, 1998). However, continuity of carer has an inherent risk. A woman and a carer might not connect and their relationship would have a detrimental effect on the outcome, contrary to expectations. Although acknowledging the benefits of continuity of carers, the current organisation of work is increasingly threatening that approach. Therefore authorities in maternity hospitals need to promote continuous care provision in order to be able to respond satisfactorily to women's requirements. Other researchers such as Hicks *et al.*

(2003), Longworth *et al.* (2001) and Fraser (1999) have also investigated this concept.

Hicks *et al.* (2003) report that women's satisfaction with postnatal service seems to rely not so much on continuity of *carer* as on continuity of *care*, or consistency in care provision. Without jeopardising the principles of the Changing Childbirth Initiative, a continuity-of-care scheme could be more easily aspired to (Hicks *et al.*, 2003). Longworth *et al.* (2001) conclude that women who value continuity of carer and who are able to choose, favour a homebirth or a setting where midwifery-led service is a target. Additionally, they value the opportunity to be in control of the course of actions and enjoy their home environment. However, this would only apply to a relatively small number of women since the rate of hospital birth is still very high.

Fraser's study (1999) largely supports the abovementioned results in terms of continuity. She describes the issue of midwives' competence from the women's perspective with the aim of influencing and enhancing basic professional training. According to her research, what women want most are good communication skills, clinical competence, continuity in caring and a special relationship with the midwife. The women in her study had complaints about insufficient postnatal parent education, incompetent help with breastfeeding and staff shortages on the unit (Fraser, 1999). The latter addresses an issue outwith professional competence. Staffing as a variable of care resources is a crucial factor in maintaining a level of quality care.

There is a range of rather intangible criteria relevant to quality care. New mothers perceive quality of postnatal care depending on how their needs are fulfilled by health care professionals but also on how women assessed the motivation of carers (Fraser, 1999; Podkolinski, 1998; Pope *et al.*, 1998). Women involved in a UK study about quality of midwifery care stated that conduct, seen in terms of having time and being friendly, was relevant for a positive perception of care in the postnatal period (Pope *et al.*, 1998). Communication skills were valued as mainly satisfactory. Conflicting advice from different midwives and a feeling of not being taken seriously concerning the baby's well-being were restricting attributes (Pope *et al.*, 1998).

Hillan (1992) comes to the same conclusion regarding conflicting advice related to infant feeding. This is in contrast with the desired aim of providing consistent care and most likely reflects a practice based on routinised procedures. This might be the result of insufficient professional knowledge and skills but also of an inadequate assessment of women's needs (Murphy-Black, 1994). However, consistency in care provision satisfies women and also contributes to professionals' job satisfaction.

Quality in postnatal care in Switzerland lacks a research-based evaluation, the exception being the evaluation of Baby-Friendly Hospitals, which focuses on issues related to breastfeeding (Merten, 2002; Merten and Ackermann-Liebrich, 2004). Attempts have been made recently to implement audit schemes on a national level but no results from such schemes are yet available. Therefore, Hasseler's evaluation study (2002), although carried out in Northern Germany, is of particular interest to the current research project.

To reiterate, the aim of her study was to evaluate the effectiveness of the service of postnatal care units in three maternity hospitals with differing caring approaches (Hasseler, 2002). Women in her study reported having a choice between continuous and partial rooming-in as a positive outcome. Additionally, they evaluated time given to recover and to be freed from everyday tasks positive. Establishing successful mother-child bonding was dependent on the length and intensity of the time spent together. Effective teaching was to some extent related to the care approach of the units and women reported greater satisfaction when they felt cared for as a dyad. Nevertheless all women expressed the need for consistent teaching. First-time mothers criticised inconsistencies and omissions more extensively than experienced mothers did. The needs of women in the three settings were more similar than diverse but all women expected an appreciative, trustful and supportive relationship with their carers. Breastfeeding outcomes were not dependent on the care approach, however women valued individual support provided in the setting following a holistic care approach. Hasseler (2002) states that the approach to postnatal care did not have as great an influence on women in their choice of the maternity hospital as professionals thought. Practical reasons such as the importance of geographical closeness and an attached neonatal care unit were more relevant for the choice of the hospital.

Comprehensive quality care is a challenge for health care professionals in the postnatal period (Fichardt *et al.*, 1994). To assure quality care, a strong focus on essential aspects of self-care and baby care is required and even more so with the decreasing length of stay in hospital and declining support at home.

In conclusion, maternity care organisation depends on national health policies and is influenced by professional power within and beyond their domain. However, postnatal care remains in the shadow of the allegedly more exciting maternity care issues of pregnancy and birth. Such an attitude disadvantages the facilitation into new motherhood and parenthood and has an unsatisfactory impact on professionals committed to this care segment. Postnatal care has faced many changes over the decades, however not all the changes have been satisfactory to care receivers and professional groups. Nevertheless, women have gained more control over the childbearing process since they were given a voice and therefore they will influence future development. Including women in audit procedures can increase professionals' understanding of women's experiences, in turn helping to facilitate changes to meet their needs. However, women's needs within this state remain vague. As a result, in the next section the way into this phase, described as the "liminal" phase and the needs it implies are explored in more depth.

Women's Needs of In-Hospital Postnatal Care

In-hospital postnatal care provides a space for new mothers for a limited time after birth. This phase in which postnatal care takes place is described as liminal phase and is understood as an intermediate phase, "betwixt and between" the normal, day to day cultural and social states (Turner, 1967:93). The term 'liminal' comes from the Latin *limen*, meaning "threshold" (Concise Oxford English Dictionary, 2001), and implies a passing from one stage to another. In this particular space, procedures and rituals may be enacted, which serve to develop individual roles or social status. In these events, time itself becomes liminal, as does the experience of the self. During this liminal phase women go through the process of transition to new motherhood. At the same time recovery from birth and adaptation to the new self takes place, as well

as the acquisition of knowledge and skills for self-care and childcare. Needs transpire from the experiences the women have in hospital, the knowledge and experiences they bring with them.

Originally developed in the field of anthropology, Turner (1967) studied a ritualistic behaviour of an African tribe and described it by using the concept of liminality. However, liminality as a concept was already recognised in the great world religions (Turner, 1969) as life on this earth was seen as a transition in itself. In more recent times, the concept of liminality has been adapted for use by other social scientists in their attempt to understand a variety of sociological and illness situations. Specifically within the subjects of maternity, Mahon-Daly and Andrews (2002:61) for example investigate mothers and reasons why breastfeeders experienced “being in a liminal period”, and why breastfeeding itself, at times is “a liminal and marginalised act”. Additionally, Sharpe’s study (1999) explores space and experiences of childbirth. She discusses the territorial conflict in childbirth and women’s autonomy in decisions over their bodies.

The use of the concept of liminality in the discussion section of this study is to emphasise the ‘betwixt and between’ state in which women find themselves marginalised while they are on the postnatal unit. The identifiable boundaries of the liminal phase for women who become mothers for the first time are admission to the unit and discharge. Within the understanding of marginalisation, space becomes central as postnatal care is hospitalised and separated from the women’s home. Women are unfamiliar with this space as it is an artificial surrounding and they are in an exceptional position as care receivers within a so-called natural experience of transition to motherhood. The next section aims at identifying women’s needs regarding their time on the postnatal unit.

Needs in postnatal care

Rather than attempting a comprehensive review of the literature on need, this section will examine only a selection of literature which aids understanding of the specific issues of postnatal care needs. Need is a central concept in nursing but the

conceptions of it are “always socially constructed” (Holmes and Warelw, 1997:469). Bradshaw (1972) conceptualised four types of need: normative need as a desirable standard defined by experts; felt need as one which is not always openly expressed but what is wanted or desired in a subjective way; expressed need as a demand as represented, or a felt need turned into action; and finally comparative need as something usually defined from above, in which individuals in need of a service make an attempt to attain equity as it is presented to others (Bradshaw, 1972).

It is highly likely that all four types of need feature in postnatal care. Furthermore, women are likely to present what their needs are, either overtly or covertly. Yet professionals are challenged to create interactional conditions to facilitate the expression of needs. Comparative needs appear to depend on resources and services offered and are open to scrutiny by care receivers and place demands on service providers. Need-fulfilment is to serve women in this liminality as there is not a universal understanding of need and such a concept is interpreted on the individual background of a person and the socio-cultural context. Despite this, health care professionals in maternity care often assume they know what women need and fail to assess their individual needs. This is no longer adequate since receivers of care today have insight into what is available and articulate what they expect to receive. Nevertheless, a comprehensive prediction of what needs will transpire post-birth is impossible for women who become a mother for the first time. This section aims to introduce research on how women prepare for the postnatal time and what their anticipated and real needs are postnatally. There are a few studies relevant to the subject under investigation but again here, I will refer predominantly to Hasseler (2002) since her study contributes the most relevant knowledge to this subject.

Anticipated needs and antenatal preparation

Health care professionals in maternity service have an obligation to provide care which facilitates the growth into motherhood on every level. This is challenging considering the various cultural and social elements of a multicultural society. Preparation for motherhood is multifaceted and is a process over time. Engaging in familial and social network groups provides the best preparation for motherhood as

Nolan (1997) argues. However, migration and demographic alterations have had a detrimental effect on such traditional systems. Another major change is that women today lack experience in mothering skills since their family backgrounds do not necessarily entail caring for a younger sibling (Murphy-Black, 1994). Similarly, many women have not had the opportunity to engage in caring for young children outside their own families before they become a mother. Furthermore, the demanding working lives and careers that many women have today lessen opportunities to engage with peers who already are mothers. As a result, an appreciation of needs during the early postnatal phase is limited and women who become a mother for the first time are less aware of what they need to prepare for.

During pregnancy there is a concentration on the self and the body, and on birth as the long-awaited event (Smith, 1999a), and little thought is given to what will be afterwards. Having a baby and caring for her or him remains difficult to imagine. Nevertheless, women are concerned with potential issues post-birth. They prepare the necessary equipment for the baby, talk to peers, read childcare and child developmental literature and engage in childcare issues.

Barclay *et al.* (1997:726) find that previous experience with childcare helped first-time mothers in their study “to feel more prepared for the process of becoming a mother”. Contrarily, Pridham and Chang (1992) note that women in their study did not feel significantly supported in the adaptation to the role with a new infant although they had previous experience with childcare. However, they also state that younger mothers in their study were usually less experienced and this affected their care-taking competence in a negative sense (Pridham and Chang, 1992). Littlewood and McHugh (1997) reason that limited experience with childcare causes additional stress and anxiety. Ruchala and Halstead (1994) describe how the woman’s own mother as a ‘role model’ influenced her and the way she cared for the baby. If this influence was a positive experience for the new mother, her confidence was strengthened.

What transpires from the above is ambiguous to some extent, however previous experience with childcare appears to be an advantage. Since increasingly fewer women are endowed with such experiences, antenatal education has become crucial

in supporting women as they prepare for their new role as a mother. However, antenatal education only appeared on the health service agenda rather recently (Nolan, 1997). Such programmes offer women an opportunity to gain knowledge and understanding of the process of becoming a mother, and hence to become aware of their needs.

Despite this, attendance at antenatal education classes is an issue of concern to health care professionals. Women attending such classes are mainly white, well educated and from generally affluent socio-economic backgrounds. Women from lower or working classes or deprived women do usually not attend (Nolan, 1997). Hasseler (2002) confirms this and states that not all first-time mothers in her study attended such classes, especially the younger women. However, attendance is not the only issue. As mentioned earlier, Hasseler (2002) and Underdown (1998) raise complaints that the focus in antenatal classes remains more on birth than on issues of postnatal experiences and on the transitional process for women and parents. Whether it is the women or the antenatal educators who are emphasising these issues is a question of debate but Moran *et al.* (1997) and Pridham *et al.* (1991) stress that health care professionals pay closer attention to the antenatal education concerning birth preparation for first-time mothers. Hasseler (2002) adds that the postnatal phase is edged out by professionals as well as by care receivers in antenatal education. This is also mirrored by the idealised picture of the childbearing process in the media.

The overall aim of antenatal education is to support women in the transition to motherhood. Nolan (1997) suggests the following aspects should be considered relevant in such programmes:

To build confidence and self-esteem so as to enable parents to take control over their labours and the birth of their children; to enable parents to ask questions and seek information so that they can make informed choices and communicate more effectively with health professionals; to increase awareness amongst women of their own bodies/feelings/needs so that they can achieve positive physical and mental health; to educate about the course of pregnancy, labour and the puerperium so that possibilities for maintaining normalcy can be explored; to challenge the notion that health issues should be left to medical experts and so encourage parents to take responsibility for their own health and the health of their children. (Nolan, 1997:1201f)

Antenatal education also provides the opportunity to meet other expectant mothers. Such gatherings are welcomed by women as it helps them to share experiences and to build a new network (Nolan, 1997). This is crucial to women as they face a major

change in their lives and a shift within their interests, hence a need to reconstruct their social networks.

The effects of antenatal education and in particular health information about self-care and baby-care issues was the subject of a large study conducted in the USA (Moran *et al.*, 1997). Of 540 participating first-time mothers questioned postnatally, three-quarters of them had attended antenatal education classes. Postnatally, no differences were found in needs for information between women who had attended antenatal classes to others who had not. The researchers argue that antenatal classes fail to address postnatal care issues but also point out that if that information is provided, it might be difficult for women to retain (Moran *et al.*, 1997). Waters and Lee (1996:367) suggest that “additional preparation should be considered by health care professionals to help facilitate the transition to motherhood”. In that respect, McQueen and Mander (2003) suggest addressing support issues in antenatal education since many women struggle to cope with fatigue post-birth, compounding the transition to motherhood.

However, health care professionals may find it difficult to provide effective preparation because of the misperception that “once the baby is born, everyone lives happily ever after” (Rubin, 1975:1684). In antenatal classes there is also an air of unreality regarding care needs because many women are unable to imagine how their lives will be altered by the birth and because of the unavoidable fact that the process of real mothering only begins with the birth of the child.

As mentioned above a real preparation for life with a child appears to be difficult. There are doubts about how and to what extent antenatal teaching prepares women for their responsibility. Evidently there is a strong focus on the event of birth, which seems to reduce the attractiveness of postnatal care issues. Nevertheless, previous experiences and an exploration of the subject help women to identify their needs.

Women's needs in postnatal care

It appears that postnatal care needs are influenced through previous experiences as well as through experiences in pregnancy and birth. It is therefore clear that

comprehending women's needs in the postnatal care setting means understanding their experiences and expectations. This shows the fluidity of the process and justifies seeing the process as a whole instead of fragmenting it in 'antenatal', 'intrapartum' and 'postnatal'. Rennie *et al.* (1998) state that women expressed differing expectations and their needs would vary before and after birth. This implies that needs change while women are on their journey to motherhood. Green and her colleagues (1990) suggest that health care professionals ought to be responsive to the changing expectations and demands of women.

A classic example considering women's needs is Laryea's study (1989) carried out in the UK. The purpose of her investigation was to examine the perception of becoming a new mother and the needs as seen from the woman's and the midwife's perspectives. Based on ideas of a previous study (Laryea, 1980), she explored women's (n=44) needs and the care given by midwives (n=20) in two hospitals during the early postnatal stage and at home by community midwives (n=20). Observation of caring situations, formal interviews, notes of informal discussions and medical records provided the data.

Considering needs, Laryea reports that midwives and mothers held conflicting views on the priority of first-time mothers' needs. While midwives prioritised 'maintenance of maternal physical health' and 'giving practical help with the infant', women placed 'understanding emotional needs of mothers' first and 'teaching infant oriented skills' second. Although midwives claimed to consider responsibility for the baby an important task for the mother, they frequently usurped this responsibility by making decisions about childcare for the woman. Midwives also failed to recognise the importance of early maternal-infant contact and as a result they advised the women to limit cuddling in order not to spoil the child. This advice was given even though rooming-in practice was encouraged. Thus although the structure provided for increased physical contact of the mother and baby, the professional advice seemed to limit actual contact (Laryea, 1980; 1989). It would appear that the contradictory priorities of the new mother and the midwife are derived not only from differing views of motherhood but also from unsystematic and insufficient assessment of individual mothers' needs.

In Bondas-Salonen's study (1998b), introduced in Chapter One, the nine participating women expressed their needs for caring and support from professionals and lay people and how it enabled them to care for themselves and for their child. Those new mothers valued experiencing care from the social network, so-called "natural lay care" as a "reciprocal relationship of mutual caring" (Bondas-Salonen, 1998b:171). Women were aware of the absence of care from professionals or they felt that routinised and task-oriented care had a harmful effect on them. To feel respected as an individual but to be seen as a new mother entails that professionals understand the meaning of caring, and are helpful and competent. Task-oriented hospital care management does not meet new mothers' needs and as the researcher argues it is designed for the personnel's convenience and not to benefit the mother (Bondas-Salonen, 1998b). However, I would argue that there are general needs postnatally, which have to be attended to. Task-orientation in accordance to guidelines can do justice to such needs, although individual needs would get lost within such an approach.

An explanatory qualitative research study conducted by Fichardt *et al.* (1994) in South Africa aimed to determine the needs of postpartum women. A heterogeneous group of 40 first-time and experienced mothers was interviewed two and five weeks postnatally in order to identify earlier and later problems, although the researchers found that most problems occur in the first two weeks. The timeframe of data collection comes close to the six-week period considered necessary for the bodily return to the pre-pregnant condition. In their study, needs were identified from problematic areas and related to self-care and baby-care with a clear emphasis on the former. Hygiene, comfort and nutrition were applied to mother and baby, self-esteem/control, activity and relationship issues were added for the women only. Information about general problems and improvement of health are important issues in baby care (Fichardt *et al.*, 1994). Concluding remarks from the researcher were that women's self-care issues need to be considered and postnatal education needs to be more strongly emphasised.

Hasseler (2002) states that women she interviewed did not give much thought to the time after birth, hence they did not prepare sufficiently for it. In postnatal care what women wanted most was practical and effective care and guidance, answers to their

questions and help with problem-solving but the need for emotional care was not made explicit. They also wished to decide what level of rooming-in was best for them. Individualised care was dependent on time, understanding and empathy of the professionals. Women appreciated professionals with an open and sympathetic communication style who were supportive and helpful yet unintrusive. There was an unmet need for postnatal education since there were no systematic education programme provided in these three settings (Hasseler, 2002).

The reviewed literature suggests that a consistent and regular assessment and evaluation of the individual mother's needs are of the utmost importance in order to plan and provide adequate postnatal care interventions. Within this falls the relationship between women and professionals, an issue raised in midwifery literature (Calvert, 2002; Fleming, 1998; Walsh, 1999). The issue of partnership between midwife and woman was also of interest to Thompson (2003), which led her to investigate that subject from an ethical perspective. She gained insight into the nature of partnership and revealed that there could be a danger of inferiority because lay people perceive professionals as authoritative. The primary goal for midwifery is to engage in a supportive partnership with the women and this prime relationship is with the woman, whereas "the mother's prime relationship is with her baby" (Thompson, 2003:598).

Crichton (1997) presents an assessment model of needs, which symbolically includes a pair of hands as the sign of friendship in the collaboration between woman-family and midwife or other health care professionals. She argues that the adaptation from nursing models to midwifery has proven to be difficult because of the emphasis on illness and dependency in nursing. Her approach is mother-family oriented and the prenatal, intrapartum and postnatal periods are seen as a natural and maturing experience. Knowledge and understanding of the socio-cultural/financial, physiological, psychological and spiritual concepts constitute the basis of an individual assessment of needs. Factors such as knowledge and skills, expectations, reliance, pressure and stress are included within this model.

Postnatal care is portrayed as a complex construct influenced by many factors: the perception of health care professionals; social, organisational and political structures;

and the needs of women and their social networks. Such complexity clearly challenges the professionals' competence, but also the service structure and its resources. It is therefore important to explore in the current study what needs transpire from the participating women on their journey to motherhood while they are on the postnatal unit and how the professionals respond to those needs. Attention will also be paid to the fact that the stay on the postnatal unit is liminal and the effect this has on women's care needs and their experiences. Preparation for this liminal phase post-birth and beyond appears to be difficult. This is most likely a result of the neglect of this segment of maternity care, which has meant that education for women is neither provided sufficiently nor received comprehensively.

Having explored what women need, I will now turn to postnatal care provision. Support and care are two concepts which aim to help professionals respond to women's needs. Considerable attention has been given to these concepts in the literature, which are explored in some detail in the next section.

Support and/or Care

The nature of support and care in the postnatal phase is widely addressed in maternity care literature but the rationale for either using *support* or *care* is not obvious. The term *support* as defined in The Concise Oxford English Dictionary (2001) is 'the action or the state of being so supported' and 'assistance, encouragement or approval' and it is 'the action of supporting or the state of being supported'. *Care* is described as 'the provision of what is necessary for the health, welfare, maintenance, and protection of someone or something' whereas the action of care means to 'look after and provide for the needs of someone'. In maternity care literature, less specific tasks were more likely to be circumscribed as support and the term support usually occurs with a specification such as 'social'. Social support, as Oakley (1992) argues, overlaps with friendship. The notion of friendship or partnership does not feature in caring literature but the notion of the interactional relationship is prominently used (e.g. Morse, 1991; Travelbee, 1971). This section investigates the concepts of support and care.

Social support

Social support as a multidimensional concept has been used in a variety of disciplines and is linked in the literature with significant life events, stress and coping (Kahn and Antonucci, 1980; Leavy, 1983; Lin *et al.*, 1979; Oakley, 1992). Oakley (1992) has made particularly important contributions in the area of motherhood paying attention to the social relationship and the well-being of women and their babies. The term 'support' is often used without clear definition and is generally understood as doing something good. Oakley (1992) points to research evidence on serious illness that suggests that social support in general is good for health but is not always a positive experience either for the receiver or for the provider. However, nursing and midwifery use the term 'social support' and the background knowledge they use is shared with the more established research areas of sociology and psychology. Hupcey (1998) critically analyses the concept of social support as used in a variety of literature. She claims definitions of social support "tend to be vague and simplistic and rarely specify types of relationships, interactions between the provider and the recipient or the actual needs of the recipient for support" (Hupcey, 1998:1232). There are common characteristics in definitions, which are linked to a network with positive interactions and activities provided to the recipient of support. In Hupcey's article (1998), five categories of theoretical definitions are identified, which relate variously to the type of support provided and the supportive behaviour of the provider; the recipient's perception of support; the provider's intention and behaviour to enhance the well-being of the receiver of support; the exchange of resources between provider and receiver, or support within a wider social network. The attributes attached to social support depend on the research area and it either can enrich or confuse the use of this concept on a theoretical level (Brown, 1986).

Dimensions of social support

The multifaceted concept of social support deserves a definition that includes social elements as well as support elements. Oakley (1992) presents an overview of what social support is and indicates that Cobb's definition (1976) is the most often quoted on the conceptual and theoretical level. His definition is as follows:

Information leading the subject to believe that he is cared for and loved, (...) esteemed and valued, (...) [and] that he belongs to a network of communication and mutual obligation" (Cobb, 1976:300).

In connection with a randomised controlled study of social support and childbearing, Oakley (1992) reaches a definition, which explicitly excludes clinical/physical care and corresponds to the definition above.

The provision of a non-judgemental listening ear, discussing with women their pregnancy needs, giving information when asked to, and carrying out referrals when appropriate to other health and welfare professionals and voluntary and statutory agencies (Oakley, 1992:144).

Such a description comes close to the notion of caring. However, ignoring practical and physical aspects and related interventions would not qualify as in-hospital postnatal care. Nevertheless, various authors incorporate the practical aspect to their conceptualisation. It is either aid (Kahn, 1979), material help (Jacobson, 1986) or instrumental help (Lin, 1986) and these feature as a distinct dimension of support. Lin's comprehensive definition (1986:18) of support is as follows: the "perceived or actual instrumental and/or expressive provisions supplied by the community, social networks, and confiding partners". The three levels symbolize the social environment of human beings as support providers. The community as the outer layer is represented as a rather loose but important network, which can confer "a sense of belonging" to and participating in social activities within a familiar environment. Whilst it is important to have a sense of social boundaries, this layer has the least effect on an individual's well-being. Relatives, friends, colleagues and professionals form the next inner layer and these people are more directly accessible and provide "a sense of bonding" to the individual. Well-being is affected more strongly from those belonging to the middle circle. Reciprocal and mutual exchange and responsibility are expected from close partners. Such relationships give "a sense of

binding” and thus have a considerable effect on the individual’s well-being (Lin, 1986:18ff).

Lin (1986) assigns two dimensions to support: *instrumental* and *expressive*. Using a relationship to achieve a goal in practical terms and material matters forms the domain of *instrumental* support. Schaefer and her colleagues (1981) name this type of support ‘*tangible* support’. Emotional support is in Lin’s understanding (1986) within the *expressive* dimension whereas Schaefer *et al.* (1981) use the explicit term ‘*emotional* support’. Lin (1986) prefers the term *expressive* to *emotional* support as it entails a broader view including a spiritual dimension and also the reciprocity between the people involved, reflecting its interactive nature. This dimension of support entails: “the activity of sharing sentiments, ventilating frustrations, reaching understanding on issues and problems, and affirming one’s own as well as the other’s worth and dignity” (Lin, 1986:20). A further dimension is presented by Schaefer *et al.* (1981) which is *informational* support. This consists of giving information and advice in solving problems and providing feedback about a person representing him or herself. Jacobson (1986) presents another formulation again, separating support into three dimensions: *emotional*, *cognitive* and *material* and he argues that all other typologies are derivatives of this classification.

This brief overview shows the different classification of social support and the language used to conceptualise social support. The utilization of such an inconsistent concept without a clear frame of reference has become challenging to researchers and practitioners but the concept itself is useful and finds application in nursing research. However, in order to utilise the concept of support, a definition is needed to give delineation to the various dimensions.

Provision of support to first-time mothers

First-time mothers undergo a psychosocial transition and attention has to be paid in the early postnatal stage to meet the specific needs they have at that time. Jacobson (1986) draws attention to time in relation to types of support and stressful events and refers to stress and coping literature.

Coping with stress is a process that involves different types of support at different times and reflects the continuous development of appraisals and reappraisals of the shifting relationship between an individual and the changing demands made upon him or her (Jacobson, 1986:252).

Such a continuous adaptation is inherent in the process of becoming a mother considering the timeframe of months or even a year it takes to adapt to the new role (Mercer, 1985; Rogan *et al.*, 1997; Tulman *et al.*, 1990). Experiences and related needs alter and therefore the types of support needed at different stages of the process as well as the providers of support change over time (Barclay *et al.*, 1997). Since this study focuses on the early postnatal phase, Tarkka and Paunonen's study (1996b) is particularly interesting as they investigated support to mothers during their hospital stay post-birth. The sample in their study consisted of 160 Finnish mothers who had had a vaginal birth, 40 per cent of them were first-time mothers. Data were obtained by a questionnaire containing ten structured questions and one open-ended question, which inquired about women's experiences of their stay in hospital. The questionnaires were handed out to women immediately after childbirth and returned before they were discharged. The researchers adopted Kahn's conceptualisation of social support (1979) as "intentional human interaction", which entails the three elements *affect*, *affirmation* and *aid* (Tarkka and Paunonen, 1996b:1203). Those categories were used to organise the women's reports of the support they had received.

In Tarkka and Paunonen's study (1996b), women reported *concrete aid* as the type of support they received most. This included practical help with caring tasks, teaching caring issues and preparing women for discharge. *Affective* transactions, which are understood as appreciating, admiring, respecting, loving and creating a sense of security were least likely to be received. Furthermore, *affirmation* seems crucial in order to construct meaning out of experience (Kahn, 1979). The element of affirmation involves reinforcing and influencing women's decision-making abilities and providing feedback about their maternal behaviour. The results show that first-time mothers received more *affirmation* than experienced mothers did but it was noticed that the older the women, the less affirmation they received. It was assumed in the study that women reported support because it was effective whereas ineffective behaviour was less likely to be reported.

A large number of women in this study reported that nurses were not interested in information about the emotional changes after childbirth and that supportive persons such as family members including the father were not involved in receiving guidance about childcare. Nurses provided more affirmative and affective support to first-time mothers than to experienced mothers. Women reported a friendly but hectic atmosphere on the unit. They mentioned they had hoped for more guidance in childcare and breastfeeding. Perceived time pressure on the staff was expressed to excuse the lack of guidance and advice.

Tarkka and Paunonen (1996b) conclude that although breastfeeding was considered important to facilitate growth into motherhood and building a relationship with the child, women received little reassurance in this respect. Furthermore women's conditions and abilities were not assessed carefully in order to provide the necessary help. Inconsistency in informing and teaching the women occurred. The researchers recommend continuity of care provision after discharge from a holistic perspective in order to meet the demands of the family (Tarkka and Paunonen, 1996b). This claim lacks further explanations about what systematic and holistic care would entail.

Framework of maternity care

Support in maternity care needs to be placed within a framework to inform professionals more fully. Such frameworks are introduced in midwifery literature. Ball (1987) presents a diagram, which she calls the 'support system deckchair', to illustrate the interactive framework with the social network in which a woman makes the adjustment to motherhood. Podkolinski (1998) slightly modifies Ball's model. The constituting elements of this framework are: society's attitudes, resources, and concerns for mother, father, baby and family; all professional groups within maternity service; support from family and peers; the mother's personality and her previous experiences. These elements determine a woman's well-being, and thus support adjustment to motherhood. This metaphorical diagram mirrors a holistic perspective of maternity care in which support is provided.

Another model of midwifery care is presented by Rooks (1999). As mentioned earlier, her description relates mainly to care of women during pregnancy and labour, which shows a clear dismissal of the postnatal phase. Rooks (1999) compares her proposed model with the medical management model. The latter sees pregnancy and birth through an illness-oriented lens, which results in insufficient support for women. Therefore, her midwifery model of care suggests midwives establish a relationship in which the woman is perceived as “an active partner in her own care” and is recognised as “the primary actor and decision-maker” (Rooks, 1999:371). Professionals help with the identification of problems, provide information and offer options to enable women to make decisions. The interest of the professional is in the woman as a unique person with her unique beliefs, embedded in an exclusive social context with her individual experiences, expectations and perception of the situation (Rooks, 1999). Provision of care within such a framework would not permit merely routinised and standardised care.

As discussed above, social support as a concept has limitations and Ball’s (1987) and Rooks’ model of maternity care (1999) show that maternity care needs to be placed into a broader context. As already mentioned, the concept of partnership features frequently in midwifery literature, sometimes appearing as friendship as one aspect of a framework. Midwifery service advertises partnership with women to make a clear distinction between them and the authoritative male-dominated obstetrics. Various authors with feminist backgrounds believe that partnership with women makes an essential contribution to the outcome of care (Edwards, 2000; Kirkham, 1986; Klima, 2001). In a trusting relationship women can learn and grow into their role and responsibility within the family. It appears that power equity between midwife and woman and participation in decision-making are important within this caring situation. Women in Bondas-Salonen’s study (1998b) expressed the view that sharing the new life situation with significant others was essential. The view brought in by Fleming (1998) is of interest since she explicitly asked New Zealander women what they thought about partnership with midwives. These women did not share the midwives’ view that they were working in partnership since they engaged with midwives in a similar way as they did with obstetricians. Likewise, Edwards (2000) argues that woman-midwife relationships are frustrating but also enhanced the

process of becoming a mother. Professional knowledge and adherence to the medical model of childbearing places midwives unavoidably in a more powerful position.

Nursing does not use the term 'partnership' or 'friendship' and talks instead about the 'patient-nurse interactional relationship' (Morse, 1991; Travelbee, 1971). Travelbee (1971) describes the phases two individuals go through leading them to a human-to-human relationship. Morse (1991) describes different types of relationship, which depend on the duration of the contact, the needs of the patient, the commitment of the professional and the patient's trust in the professional conduct. However, in midwifery the term 'patient', as argued earlier, would not apply to healthy low-risk childbearing women. Midwives prefer a partnership role rather than a dominant role. Crichton (1997) argues that nursing models focus strongly on illness-related issues rather than on promoting health.

In King's understanding (1981), the principles of nursing are to promote, maintain and restore health. Nursing practice aims to respond to the receiver's behaviour and expressed needs on an individual level. Nurses engage in communicative actions and mutual understanding. Nursing is practised within rational, cultural and economic constraints, adapts to the current demands of a society and develops knowledge in order to respond to cultural and social change.

Since maternity care involves professionals from nursing and midwifery it is a challenge to derive a philosophical background on which both professional groups could draw. As mentioned earlier in this chapter, there are settings where several professional groups provide care to pregnant and childbearing women and new mothers. In the particular setting where this study was carried out, general and children's nurses with different qualifications care for mother and child postnatally whereas midwives care for the mother antenatally and intrapartum.

The concept of caring has been acknowledged for decades and several middle-range and grand theories of caring exist. However, there are only a few relevant to maternity care. As introduced in Chapter One, Mercer's theory (1986) of 'maternal role attainment' is well known. Amongst the several concepts she defines social support rather briefly. She defines it as entailing provision of information and feedback, anticipatory guidance and teaching and remains largely on the level of

hands-on nursing activities. However, these aspects are relevant to nursing as a health care profession (Mercer, 1986), as they are important to women and men along the journey to becoming parents.

A middle-range theory of caring was empirically developed by Swanson (1991) in the field of maternity care. This theory describes caring as “a nurturing way of relating to a valued other toward whom one feels a personal sense of commitment and responsibility” (Swanson, 1991:162). The broad scope of the theory makes it applicable to many areas in nursing. It also serves the purpose of providing a frame of reference crucial for caring for first-time mothers. In the following section, Swanson’s conceptualisation of caring is outlined and its relevance to the current study is explained.

Conceptualisation of Caring

Caring as an important concept within nursing is gaining increasing attention in the literature and this has led to the development of several caring theories. Based on a human science perspective Swanson (1991; 1993) introduced a theory of caring and her philosophical thinking seems relevant to the field of postnatal care. Moreover, this theory emphasises caring and the interactional perspective. Analysing postnatal care provision with help of this theory brings us to the core of nursing.

A theory of caring

Swanson’s middle range theory of caring (1991) was empirically developed in the late eighties and early nineties from three separate phenomenological studies in the maternity care field. Therefore this theory is considered relevant to the investigated phenomenon.

Swanson (1991) developed this theory from three data sources: women who had recently miscarried; care providers in a neonatal intensive care unit and pregnant women who were at risk and enrolled in a public health intervention programme.

Swanson claims (1991) her theory of caring is applicable to any caring relationship. However, later and in a more detailed description of the dimension of the theory, she limits the applicability to nursing only. Caring occurs where receiver and provider meet within a structured context and schedule and this holds a high degree of fluidity. She introduces professional knowledge as a basis for performing informed caring. The four components of professional knowledge are: empirical, aesthetic, ethical and personal knowledge, and these inform caring (Carper, 1978) and influence the caring process.

‘Maintaining belief’, ‘knowing’, ‘being with’, ‘doing for’ and ‘enabling’ are the five caring processes of a positive contribution to the client’s well-being (Swanson, 1993). These five processes can be understood as overlapping dimensions within the phenomenon of caring. Swanson concludes that the proposed structure:

depicts caring as grounded in maintenance of a basic belief in persons, anchored by knowing the other’s reality, conveyed through being with, and enacted through doing for and enabling (Swanson, 1993:357).

In order to improve her understanding of the theory and the relational ties, Swanson (1993) gives a structure to the caring processes. At least two human beings are involved in a caring situation. The recipient and the provider of care are present in the situation with their attitudes and knowledge, actions and outcomes resulting from what is mutually recognised. In the following section the five caring dimensions are described.

The first of these is ‘maintaining belief’. This refers to caring as believing in the clients’ abilities to get through life events or transitions. On an interpersonal level the nurse will help to sustain faith in the capacity that mothers or parents will be able to cope with joyful or painful experiences. The nurse will also help to create a way of accepting outcomes and that the parents will have faith in a meaningful future. ‘Maintaining belief’ is not only important on a personal level; it is of fundamental importance to nursing that it believes that people are capable of coping with difficult life events and that the profession is committed to serving society.

The second dimension is ‘knowing’, the process of informed understanding of events as they have meaning in the life of the human being. ‘Knowing’ links nurses’ beliefs to the reality of the person cared for and what the receiver asks for. The fusion of the

four components of professional knowledge with the individual caring situation brings out informed understanding, which is key to therapeutic actions.

The third dimension is 'being with' the receiver of care. The nurse conveys the message that she is emotionally present and shares in the receiver's meanings and lived experiences. This caring process is placed in the centre of the theory, which marks the core of nursing.

The fourth dimension is 'doing for'. This is the therapeutic action whereby the nurse does for the receiver what they would do for themselves if it were possible. 'Doing for' in a competent and skilful way includes comforting the other, anticipating their needs, protecting them from harm and preserving their dignity. In terms of practical activities, 'doing for' involves communicative actions which address the psycho-social realm of care.

The fifth dimension is 'enabling' which is "facilitating the client's passage through life transitions and unfamiliar events" (Swanson, 1991:162). Coaching, informing and explaining are therapeutic actions which aim to ensure the other's long-term well-being. Moreover 'enabling' leads to the empowerment of the person cared for.

This conceptualisation of caring entails caring actions, which are aimed at improving the client's well-being. Swanson (1993) further defines personhood, environment, health and well-being, and the role of the nurse. Nurses have an obligation to maintain the care receiver's autonomy and self-determination. Their conduct includes the combination of scientific knowledge, the careful examination of the care receiver's concerns and their engagement in caring for them. Nurses' responsibilities are described for the individual but also for society at large. Within the five caring processes there is guidance for professional behaviour although this appears rather thin when it comes to ethical problems, failure or decompensation.

Caring as a concept has been acknowledged in nursing for decades, whereas in midwifery the concept of 'social support' features more prominently. Nevertheless, midwifery has made an effort to conceptualise provision of support within a holistic perspective. This review has highlighted the need to explore the nature of care in the postnatal phase, the nurse-woman relationship, and the effect of this on women's perceptions of care provision. The history of postnatal care, its rapid politically

driven development and the medical emphasis all provide a rationale for the lack of recognition of the importance of care as an activity in its own right in this care segment.

Summary and Rationale for the Study

This chapter has introduced the difficulties specific to postnatal care. These are mainly caused by political factors, by the structure of postnatal care and also by society's and professionals' lack of appreciation. These issues demonstrate how care in general is influenced by societal changes, how postnatal care specifically is affected both by political rigour and the current notion of motherhood in the Western world. An attempt to update the response to those changes is justified within a modern and competing health care system. However, this proves a challenge to health care professionals since it requires constant appraisal and re-examining of professional conduct, as well as the development of adequate care interventions and support systems in constrained working conditions.

In the UK, provision of postnatal care is the domain of midwifery. In other European countries, nurses with general or specific qualifications are involved in it. Whatever qualifications professionals possess, it is well acknowledged that good quality maternity care contributes to the well-being of mother, baby and family. Despite this, for a long time postnatal care has been fragmented, standardised and routinised. It is also clear that this has been more for the convenience of the personnel and the institution than for the women. In this respect, more recent literature, despite largely drawing on retrospective accounts, reveals the salience of examining mothers' experiences and their needs and how they evaluate postnatal care. Most women have a vague awareness of their needs when entering hospital for their first birth although there is a shift towards an informed understanding. Exactly what being a mother entails can only be fully grasped when motherhood is experienced. The length of time needed to grow into motherhood needs to be acknowledged. Research findings emphasise the importance of individualised care entailing postnatal education and enabling women to care for themselves and their babies. Interactions in the postnatal

care situation between women and professionals should be based on an understanding of the process of transition and the associated experiences. Mutual respect is vital for successful interventions and it is crucial to provide professional support, which enhances women's well-being and enables them to fulfil their maternal tasks. The majority of women who become mothers are of low risk and hence considered healthy. Illness-orientated thinking has to be less accentuated in maternity care for the sake of the healthy women who become mothers. Despite their 'healthy' status, there is considerable evidence that women are in a vulnerable state in the early time post-birth and therefore need attention from professionals as well as from their social network.

In the literature reviewed, 'support' and 'care' are terms often used interchangeably. An examination of the two concepts reveals that despite an inherent similarity, both have been difficult to conceptualise. 'Support' is multidimensional and it consciously includes the recipient and the provider for the purpose of mutually agreed and helpful interventions. Definitions of 'care' tend to emphasise a deficit orientation caused by physical and emotional vulnerability and ill health. Nevertheless, helpful interventions to restore health and recovery are at the heart of care provision. Although low-risk women are considered healthy, their emotional vulnerability justifies a caring attitude from professionals. Both concepts prove to be relevant for postnatal care.

Engaging and coping with a specific form of woman-centred care within the hospitalised maternity service is a challenge for midwifery and nursing. Adapting maternity service to the journey of mother and baby, increasing service quality and flexibility and reducing cost and inefficiency are targets within that field. The theory of early motherhood introduced by Barclay and her colleagues (1997) and Swanson's theory of caring (1991; 1993) could thus well prove to be helpful in exploring and describing the patterns of postnatal care that characterise maternal and professional relations in this early phase of motherhood.

The journey to motherhood as described in Chapter One is a fluid process of different duration according to the individual's ability to cope. However, the journey on the postnatal unit is liminal and clearly marked by a beginning and an end. These

two journeys are intertwined and thus challenging for both women and health care providers. It is of interest to me how women in this study experience these journeys and how nurses perceive these women in this liminal phase and respond to them. This is explored in Chapter Five and Six and discussed in Chapter Seven. However, before turning to women's postnatal journeys and the caring relationships, I describe the way in which I attempted to achieve this. Therefore in Chapter Three the research process is outlined. Following that, and in order to gain a better understanding of the setting in which this study takes place, a description of the context is provided in Chapter Four.

CHAPTER THREE

APPROACH TO THE STUDY

Introduction

In this chapter a detailed account of the approach to the study will be given and the framework providing the context for the study will be discussed. Included in this discussion will be information on the epistemological and ontological perspective as well as on the methodology and methods. Provision of information on these is relevant so that the assumptions underpinning the research are clear.

Aims of the study

This study was designed to provide data about the care required by first-time mothers during hospitalisation following the birth of their babies, and the challenges faced by the nurses providing this care. An overall aim of this research is to develop an understanding of the complexity of early in-hospital postnatal care for first-time mothers, and to inform nursing and policy-makers about requirements necessary for successful change. The specific aims of the study were: firstly, to explore care for first-time mothers while residing as in-patients on a postnatal care unit; secondly, to identify what influences the care needs of women and how they experienced provision of care; and thirdly, to explore nurses' perceptions of women's needs and their responses to those needs.

The research questions

Research questions, as Hammersley and Atkinson (1995) argue, often arise after a research setting is chosen, or may influence the further development of a study in an unanticipated direction. In the case of this study, this occurred almost simultaneously although the influence of the site on the development of the questions was indisputable. The questions were generated from my nursing background where I identified the research problem, and from the subsequent literature review. They refer to the time during which participating women are in hospital and experience being a mother while they receive care. They are as follows:

What are women's expectations and what is it like for first-time mothers on their journey to motherhood to be in the postnatal care setting?

What is the nature of care and the caring relationship experienced by the first-time mothers and their allocated nurses?

Background

This research developed from my experience of working as a Clinical Nurse Specialist in the Clinics for Gynaecology and Obstetrics. In cooperative projects on the postnatal unit, I noted that nurses frequently commented that first-time mothers required considerable attention and many of them had a rather unrealistic view of their new role as a mother. Consequently I became curious about how care for first-time mothers was constructed. While this was the nurses' view, there was no detailed information available on how first-time mothers perceived the care they received while in hospital. I was convinced that in order to understand how nurses and first-time mothers determined and decided on care interventions, it was necessary to design a research project that considered both views. In addition to seeking information on the actual care, I believed it was necessary to ask women about their prenatal expectations of care, their actual experiences and their post-hospital reflections on the care they received. I also wanted to explore the nurses' perceptions because the interaction between the nurses and the first-time mothers is how the caring situation is constructed. I recognised that one way to assist the development of

an understanding of both women's and nurses' perceptions would be to use a design that contained components of observation, conversations and written material.

View of reality

The situation described in this study is not an objective reality because there is no single truth about how women experience becoming and being a mother. Each woman and nurse's experience has individual meaning, and the meaning they give to their experience is influenced and constructed by beliefs and practices within their cultural setting. Nurses engage in the situation based on their knowledge, skills, experiences and values (Fawcett, 1984). Their engagement is also based on their understanding of the recipient of care and their significant others, the surroundings of the recipient and their state of health, and the actions taken by them on behalf of, or in conjunction with, the recipient of care (Fawcett, 1984). What emerges from the interplay between the participants is a construction of a meaningful reality in which care is provided. Therefore the epistemological approach in this study is constructionism, which is defined by Crotty as

the view that all knowledge, and therefore all meaningful reality as such, is contingent upon human practices, being constructed in and out of interaction between human beings and their world, and developed and transmitted within an essentially social context (1998:42).

Following the view of constructionism, meaning is constructed dialectically within a given culture as it shapes the minds of human beings and the way human beings see the world around them. Culture gives human beings a way of functioning and vice versa; human beings are dependent upon culture. According to Berger and Luckmann (1967), reality is socially constructed, created and maintained on an individual and a cultural-societal level. This social dimension of constructionism directs human behaviour and organises the experiences of human beings.

Naturalistic viewpoint

It is appropriate to investigate the interaction between a first-time mother and nurse from a naturalistic viewpoint, because the naturalistic paradigm allows the researcher the opportunity to directly focus on the participants as they construct meaning.

Cultural beliefs and practices of the group under study are important to the construction of meaning. Culture in this study is to be understood in a broad sense and refers to a group of people with distinct health belief, health practices, and norms that direct expectations and provision of care (Morse and Field, 1995).

As the researcher, my engagement in data generation included observation, conversations with the women and their assigned nurses, and examination of the nursing charts. I also recognised that I influenced the construction of reality because my perception is influenced by my knowledge, beliefs and understanding of the situation under investigation. As Streubert and Carpenter (1999) note, meaning is not merely investigated, but is constructed by the researcher and participants through active and reciprocal relationships and the dialectical processes of interaction. In such a situation, Munhall (2001) advises that the researcher engages with openness in order to discover alternatives and differences. In this study, listening to the various participants and observing the many caring situations provided a wide range of information and helped me to see and understand diverse experiences and perceptions within the subject and the field.

The Ethnographic Approach

This study aims to explore the phenomenon of care of first-time mothers on a postnatal care unit in a hospital in Switzerland. The intent of this study is to examine, from an insider's point of view, the behaviour of first-time mothers and nurses, and what their experiences mean to them (Morse and Field, 1995). As Spradley (1980) argues a primary reason to use ethnography is to understand human behaviour and meaning behind the phenomenon under study. An understanding of behaviour and meaning is particularly relevant to health and illness as it facilitates the understanding of health values, beliefs and meaning systems. (Morse and Field, 1995; Streubert and Carpenter, 1999). While Honer (2004:116) converses, it is not possible to reach the inner view of participants but only "to become truly acquainted with the world in question from the outside, from some different perspective (...)", ethnography was selected since this methodology gives access to the meanings that

guide that behaviour (Hammersley and Atkinson, 1995). Ethnography incorporates essential features such as an

emphasis on exploring the nature of particular social phenomena (...), to work primarily with 'unstructured' data (...), an investigation of a small number of cases (...), and analysis of data that involves explicit interpretation of the meanings and function of human actions (...) (Atkinson and Hammersley, 1998:110f).

There is debate whether ethnography is a methodology or merely a set of methods (Atkinson and Hammersley, 1998; Wolcott, 1999). Crotty (1998) argues that ethnography is a methodology and, as such, a strategy informing the selection and use of research methods and therefore leading to the desired outcomes. While its outcomes might not be very detailed or of immediate value, they contribute to disciplinary knowledge (Atkinson and Hammersley, 1998). Researchers using ethnography are advised to be aware of the roots of the ethnographic approach, otherwise they may be not be using its methods appropriately (Atkinson and Hammersley, 1998). Ethnography has its origin in the naturalistic tradition of anthropological studies of the late 19th and early 20th century (Spradley, 1980) and, as Atkinson and Hammersley (1998) note, its particular style and substance is a twentieth-century phenomenon. Ethnography became popular again because the Chicago School reintroduced it in the 1960s and this is the main reason why it was re-discovered within the social sciences.

Leininger (1985) was a pioneer with her ethnonursing research method focusing on nursing phenomena from a cross-cultural perspective (Germain, 2001). Ethnography provides nurses with the opportunity to explore the holistic nature of society and to ask questions relevant to nursing practice. Leininger defines ethnography as:

The systematic process of observing, detailing, describing, documenting, and analysing the lifeways or particular patterns of a culture in order to grasp the lifeways or patterns of the people in their familiar environment. (Leininger, 1985:35)

Wolcott (1999) questions if one can conduct ethnographic research among one's own people. This contrasts with ethnographic research in nursing where nurse researchers always have a familiarity with the field and this is also true for this study. However, the reason for the method chosen was to become close to the participants.

There are various types of ethnographic research. A small scale or mini ethnography is focused on a specific or narrow area (Leininger, 1985). Classic ethnographic

research is conducted over a prolonged period of time within a broad cultural group. In contrast, a focused ethnography is time-limited and conducted within a fairly discrete group of people and/or organisation (Germain, 2001). Despite the different types of ethnographies, there are certain common characteristics including holism, contextuality and reflexivity (Morse and Field, 1995:23). Of these three characteristics, Wolcott (1999) suggests that holism and contextuality must be viewed together. Holism is more about connections than about completeness, as an ethnographic account can never mirror an entirety. Even in a narrow focused ethnography the researcher is required to provide a thorough description of the contextual circumstances. Therefore, contextualised reporting can be considered as holistic in the way that interrelated elements and parts are tied together. In accordance with those principles, this study will provide an account of the setting of the hospital where research was carried out, situating it within the Swiss national health policy. It will contextualise the professional and institutional policy and standards of nursing care in the hospital, and will consider backgrounds of the participants. These accounts are detailed in this and the following chapter. The research account also has to mirror the dialectical process of interactions, the interrelatedness of first-time mothers and nurses, and it has to show how data were generated. Reflexivity, the third characteristic identified by Morse and Field (1995), is understood by Wasserfall (1997:151) as “a position of a certain kind of praxis where there is a continuous checking on the accomplishment of understanding”. It is essential in ethnographic research and particularly important in this study because I was conducting research in my own professional field. As part of this social world, I carefully monitored my own subjectivity, my specific knowledge of the subject under study, and the effect my beliefs, my behaviour, and my presence had on the participants. Reflexive thoughts are presented in this chapter as well as in Chapter Seven.

The Research Process

Gaining access

Fieldwork for this study was conducted in a General Hospital in Switzerland, described in Chapter Four, with which I was familiar from my former employment. The reason for choosing this setting was not only because of easy access, but also because of the research-friendly attitude of the hospital's managers. However, official access had to be negotiated with key officials to obtain permission and Hammersley and Atkinson (1995) reason that this is important in formal organisations. I had a preliminary discussion with the Senior Nurse Officer and the Clinical Director of the postnatal unit about my proposed research in autumn, 1999. The Clinical Director expressed his interest and also expectations that this study might produce outcomes which could be important for improving efficiency and effectiveness in postnatal care provision. Such an expectation caused some anxiety (Hammersley and Atkinson, 1995) as I was not intending to evaluate postnatal care in the first instance, but rather to explore how postnatal care was constructed in this setting. Nevertheless, they encouraged me to write to the Hospital Management Board for permission for formal access to the postnatal unit once I had outlined the objectives of the study and the research design.

In December 1999, I submitted the research proposal to the Chief Nursing Executive requesting his support. I also asked him to discuss it with the Management Board of the Clinic of Obstetrics. Written permission to access the postnatal unit was granted by the Clinical Director by the end of December 1999, the Chief Nursing Executive gave verbal permission in February 2000. The proposal was then submitted for ethical approval to the Ethics Committee of the state in which this study was taking place. The president of this committee invited me to their monthly meeting in April 2000 to discuss the proposed study and advice was given for amending both the consent forms for women (Appendix One) and nurses (Appendix Two). Written approval was received one week after the meeting, stating that the amended consent forms had been accepted and the study could proceed. Subsequently, I provided all staff members working on the postnatal unit access to a copy of the research

proposal. Preceding data collection, they were invited by the Management Board of the Clinic of Obstetrics to a meeting where I discussed my proposed research with them. I also attended a meeting with the Nurse Manager, and staff nurses of the postnatal unit to introduce them to the study design, to discuss the details of data collection and to answer any questions. Nursing and midwifery students were invited to discuss the same issue as they entered the postnatal unit for their placement. I interviewed the first participating woman by the end of April 2000, began observing on the postnatal unit once she delivered in May 2000. Data collection continued in this fashion for six months.

Selection and recruitment of the study participants

Since the focus of the study was the women's experiences and expectations in becoming first-time mothers, and the nurses' care for those mothers, I had to recruit women who had registered to give birth at the study hospital and nurses who worked on the postnatal unit. In the understanding of Hammersley and Atkinson (1995) those two groups of people were considered key informants. Whereas women were chosen via purposive sampling, participating nurses were chosen because of their assignment to those women. The participating women had to be expecting their first baby but women who previously had been pregnant and spontaneously aborted were not excluded. The Obstetric Clinic at the hospital maintains a birth registration list and potential participating first-time mothers were selected from this list. An additional selection criterion for women was that they intended to stay in hospital for up to five days. This information was also readily available on the clinic database. The secretary of the senior doctor, who had also read the research proposal, contacted fifteen women approximately one month prior to the anticipated birth date. Initially she informed them about the aim of the study, what involvement would be required of participants and who was conducting the study. She also inquired if women were fluent in spoken German, which was another inclusion criterion. Women who were still interested after this initial contact were sent a letter containing further details and a consent form, as mentioned earlier. After receiving names of the women who had agreed to have letters sent to them, I telephoned to inquire if they were still interested

in the study now that they had received more information. Fifteen women were sent letters, ten agreed to participate. Of the five women who did not participate, two women had delivered prior to the set date for the first conversation, two were no longer interested after reading the material and one woman was interested but was moving to another city shortly after birth. Following verbal consent from each of the ten participating women, we set an appointment for the first conversation within the next couple of days. At this first meeting, I confirmed that the women had all the necessary information and understood the details of the research as outlined in the consent form. I then had them reaffirm their agreement by signing the form.

Recruitment of the nurses was also a fairly uncomplicated process. There were 30 diploma nurses and eleven midwifery and nursing students working on the postnatal care unit during the course of fieldwork. Obviously, all had to be provided with the opportunity to agree to, or to refuse to participate in the study. At the meetings with the diploma nurses and the students, I gave each of the potential participants a copy of the consent form and asked them to return it in the enclosed envelope within two weeks; either signed in case of participation, or unsigned if they decided not to participate. Of the 41 staff members, three diploma nurses decided not to participate. One nurse was expecting her first baby soon and the two other nurses had given notice and left the setting within the first two months of data collection.

Description of the participants

There were ten women participating in this study. The women all lived in the city or in the near rural area of the study hospital. At the beginning of the study, all women were living with their child's father. The women's age ranged from 21 to 35 years, with an average age of 27.8 years. For all women except two, it was the first pregnancy. Although not all pregnancies were planned, all women indicated they wanted a child. None of the ten women had signed up to stay in a private or semi-private section of the hospital, which means they were all staying in three-bed rooms during the time of my observation.

Eventually 20 of the 41 female staff members, fourteen diploma nurses and six midwifery and nursing students were participating. Their involvement was directly linked to their assignment to the participating women. There were five nurses participating more than once; three were involved during two shifts and two during three shifts. In reference to their experiences in postnatal care practice, the length of time of the twenty participating nurses and students ranged from zero months to 18.7 years with an average of 4.5 years. On average, the fourteen diploma nurses had 6.3 years and the six student nurses 0.3 years on average in practice in postnatal care at the onset of this study. A profile of all participants is provided in Appendix Three.

Data collection

The main study

The following section provides an account of the data collection procedures, problems encountered and how these were addressed. The organisation of this section is not chronological, it is rather arranged around the main informing sources.

The study was designed to include an initial conversation with the expectant women, followed by an observation of their care on two to three days while they were in hospital. Observation of the women's care was followed by a conversation with their assigned nurse and a final conversation with the women two to three weeks after discharge. I called this series of observations and conversations a 'set'. One set involved one woman and all the nurses caring for her and the child, on one of two to three different assigned shifts during the time of observation. Additionally, data were obtained from consulting the women's hospital records.

Assessing the research plan

Before I began data collection I had the opportunity to observe and to converse with women in a birth resource centre in Scotland. I was given access to yoga classes which were run as antenatal preparation for pregnant women, and I participated in their exercises. This allowed me to take fieldnotes of observed activities and conversation amongst and with those women. I also conducted one conversation with

a first-time expectant woman in order to evaluate my interviewing style and alter interview questions if necessary. I started with only two questions, which were the following: 'Can you tell me what experiences you anticipate for the time after your baby is born?' and 'What kind of care and support do you expect from nurses in the hospital after you have your baby?' This experience showed clearly that I had to develop a more precise guide (Appendix Four) for the initial conversation with the women. As a novice researcher, it also allowed me an opportunity to reflect on the wording of questions and on my conversational skills. Data from this conversation are not included in my study.

Before I started that exercise my inexperience in the role as an observer caused some anxiety. Many questions arose from the fieldnotes about how I could best develop skills as an observer. I assessed this form of training and how important it was to be closely supervised, debriefed and assisted in the development of research techniques (Preston, 1997).

Further assessment of the research plan occurred when I had completed my first set for this study (initial and final conversations with the woman, two onsite observations and two conversations with the assigned nurse). I made minor adjustments, including a slight change in the level of information given to the women before the observation period and a change in the timing of the observation. For example, I provided women with the information that nurses on the unit had no knowledge of the content of our conversation. Furthermore, and whenever possible, I refrained from conducting observations during the first 24 hours following birth with one exception. This decision was made in response to nurses' comments when we initially discussed the data collection procedure; they felt women would prefer to experience this very first time of intimacy with their baby and their partner without being observed. Such an omission of that early time post-birth could well lead to a limited view and understanding of the experience of transition and care provided during that period. However, I felt it was appropriate to respect the nurses' suggestions.

During this pilot stage I also determined the process that would be used for analysis. Initially, I intended to use Colaizzi's method (1978) for the entire analysis. This

seven-step framework is designed to analyse phenomenological data in order to produce a descriptive analysis. In actuality, while I was analysing the first set, I used Colaizzi's method up to Stage Three. Stage One included, reading of all verbatim transcribed conversations and notes in order to gain an understanding and feeling for them in their context. I then extracted all the significant statements from each protocol and went on to Stage Three, in which meanings from the significant statements were formulated. This initial experience of formal data analysis helped me to decide to use a computer software package as will be described later.

The conversations

All initial conversations with the women were conducted following the modified conversation guide as mentioned earlier, whereas subsequent conversations were guided by specific questions which arose during the observations. Although I call those dialogues conversation, they were in fact qualitative interviews, which in Rubin and Rubin's understanding (1995), are modifications of ordinary conversations with the aim of gaining insight into the participants' perception of their experiences and understanding of the situation. Such a form allows interviewer and interviewee to determine the course and the topics of the dialogue and where feelings can be expressed.

At the onset of a conversation, I explained the procedure, the expected duration and the main issues that would be raised during the conversation. Every conversation was successfully tape-recorded with a Philips 730 Dictation system. I explained to all participants that taping the conversation maintained an accurate account of the conversation and avoided the necessity of copious note taking. However, note taking is recommended by Rubin and Rubin (1995) as it helps to pace the conversation but it also forces the interviewer to listen carefully and to detect the main points.

The conversation venue was of particular importance to me because acquiring information in a friendly and quiet atmosphere allows for generating rich informative data. All women invited me to their homes for the conversations. This was particularly convenient for them for the final conversations because it allowed them to be with their baby in their own environment. In one set only the partner was with

us for a short time and contributed to our conversation. The conversations with the nurses were carried out at the hospital. I always made an effort to find a quiet place. It was either the office I was working in or a room on the unit where disturbances were minimal.

The initial conversations with the women

In these conversations, I intended to identify women's experiences during their pregnancy, the process of becoming a mother and their expectations of receiving care and support from the nurses while they were at the hospital. In every case, our first conversation was our first meeting and I found it important to start off with a chat to create a natural involvement (Rubin and Rubin, 1995). All of the women made it very easy for me as they usually were interested in how I found my way to their house or made other similar small talk. Before I set up the tape recorder, I explained why they were selected for the study, I made sure they understood who I was and asked them for the signed consent form. I then asked the women if it was alright to start the more formal conversation. I always encouraged the women to bring up their own questions particularly in terms of participating in the study. Some raised concerns about their own and their baby's well-being and one woman was particularly concerned about her intimacy being disturbed by my observing her. The latter was crucial to know as it made me even more aware of protecting the women's intimacy. Immediately after the talk, I made notes about the procedure, the identified elements to be observed, the women's concerns and the reflexivity of the research process.

The conversations with the nurses

The questions I raised in the conversations with nurses were based on observations I made of their care of the woman and baby during their assigned shift. The aim was to clarify how they perceived the woman's experiences, what needs they had assessed, how they responded to them and how they related to the allocated woman. All conversations were conducted within their working time but some had to be postponed to the next day or even later when those nurses felt too tired to concentrate

for the length of a conversation after a shift, especially late in the evening. At the request of one nurse, I provided those nurses who postponed the conversations with questions I would like to raise with them in the subsequent conversation. The delay of this conversation allowed those nurses to reflect in more depth on their caring behaviour, hence those conversations were more concise and usually shorter. However, the content of those conversations was equally valuable to the ones which were conducted right after completion of the shift. Notes were made after each conversation about any relevant non-verbal aspects, constraining factors and about my own feelings. The notes helped me later, while transcribing, to recall events and impressions. The conversation flowed easily because I had been able to build up a relationship with the nurses during the observation. Additionally and in the course of my fieldwork, I came to know the nursing staff members as we usually had coffee and meal breaks together and engaged in informal conversations. Some of the nurses were already known to me from my previous work in that setting, which helped us to readily connect.

The final conversations with the women

At discharge, I made an agreement with every woman to call her within the next ten days to arrange our final conversation. In all cases except one, I was able to adhere to the set time. One woman had moved to her mother's home and contacted me of her own accord after a slight delay. All final conversations were based on the observation and the conversations with the allocated nurses. I felt more comfortable during the closing conversations, compared to the opening ones. In the course of their time at the hospital, the women and I developed a relationship which allowed me to engage more freely with them. They were very open with me, discussing their thoughts, feelings and personal experiences and providing rich and very personal information.

Following this last visit, I reflected on the conduct of the conversation as well as on the whole procedure of each set. The notes taken were helpful for the initial analysis of the data and provided a source of comparison with what I found in the transcripts.

The observation

The elaborated elements from the initial conversation guided the observation process and provided first-hand data. The aim of this part of the study was to explore what experiences and needs women brought to the postnatal situation, how nurses responded to those needs and what influenced their conduct. Observation took place at the locations wherever the participating woman and the allocated nurse met during her shift. In seven out of ten sets, I was able to observe during three assigned shifts whilst in the remaining three sets only two observations could be carried out. The number of observations depended on the birth time, the woman's well-being and my own availability, as on occasion there was more than one of the participating women on the unit. I was present on the unit for observation during 27 shifts; the length of one shift is 8 hours, 24 minutes. I observed the caring situation whenever the allocated nurse was working with the participating woman, which means the actual observation time was much less since the particular nurse was responsible for the care of other women as well. I chose not to remain in the women's rooms when the nurse was absent as this would have been intrusive and possibly irritating to other women present in those rooms. To some extent I depended on the nurses to call me when they went into a woman's room but most often I would wait in a place where I could see the nurse and follow her spontaneously. My engagement in care provision in Spradley's terms (1980) was between passive and moderate participation.

The fieldnotes were handwritten on the spot, either in the woman's room or more often, in a quiet place on the unit. I usually felt more comfortable taking notes when I was on my own. Nevertheless, it was occasionally unavoidable to jot down some words, especially when it was busy in the woman's room or when the observational period lasted for a longer period of time. In most cases I would transcribe the handwritten notes immediately after the observational period or the next day. Sometimes, especially late in the evening, I was able to use the computer in the nursing office and typed my notes directly into my files. The fieldwork journal (example in Appendix Five), which I kept throughout the observation, includes reflexive thoughts and feelings I had during and after the observation and about the conversations with the participants. I also followed Spradley's suggestion (1980) to

date and sort all entries according to the sets as this helped later for a better understanding of my data.

The documentation

Beginning each new observational period, I reviewed the care plans and charts of the participating woman. This provided me with the necessary information about the woman's and child's well-being, her needs and care received. All the care plans and charts were photocopied by me after the participating women were discharged. Additionally, written material was gathered from this organisational setting, such as quality care standards and reports, for the purpose of reviewing the mission stated in such documents and to compare them with care provided.

Data management

I transcribed each conversation verbatim. Afterwards, I listened to the tapes once more whilst reading the transcripts. Corrections were made and reflexive notes taken about content and conduct. The initial conversation with the women and all nurses' conversations had to be transcribed soon after conducting them because this information was necessary for observation and further conversations. This familiarity with the data was particularly helpful in identifying emerging themes. This process proved to be time consuming but also crucial in gaining an intimate understanding of the women's and nurses' experiences. Furthermore it offered a link to the site and the opportunity to see my data within the context.

The process of data collection was recorded in a field diary. This contains important information about obtaining ethical approval, gaining access to the field, recruiting research participants as well as emerging thoughts, feelings and intuitions throughout the process. Those memos were recorded either by hand and then transferred later to the computer or directly typed into the file. In this way, I gained an understanding of my data and the emerging themes formed a base for the initial analysis.

As a novice researcher, I had limited experience with managing data. Beforehand I had the opportunity to examine two computer programmes (NUD*IST and The

Ethnograph v5.0) for organising, storing, coding and processing text-based data. I decided to use The Ethnograph v5.0 since it appeared to me a straightforward programme. I used this software package for organising, numbering and coding data. The data files in The Ethnograph v5.0 were grouped into separate projects. 'PNCare', as I named the main project, included all data and further data files consisted of Set A to L³, hospital documentation, fieldnotes, initial and final conversations with women and conversations with nurses.

Pragmatic aspects of the analysis

Data analysis started with the initial conversation with women and continued throughout data collection to arrive at another level after completion. During the process concurrent data collection and analysis was a crucial requirement for the observation, as well as for the conversations with nurses and women. At the end of each initial conversation, I summarised the main issues and fed them back to the women for confirmation. Women most often agreed on my summary or added a subject important to them. As an example, emerging elements were 'uncertainty about the new role', 'self-determination', 'support in handling baby care' and enjoying the new threesome'.

These emergent themes provided guidance for structuring the observation. A similar process was adapted to the nurses' conversations. After observing them, questions I asked nurses were, for example: What were the woman's needs and how did you understand them? The situation with the Guthrie-Test; what did it mean to you? It has been a busy morning; how did you feel about it? The elements emerging from those conversations, together with the main issues from the fieldnotes, were fundamental to the final conversations with the women. A further level of analysis took place while transcribing and rereading the transcripts.

I started the process of formal analysis after data collection was completed. At that time I still believed that searching for meaning in the various components would

³ In assigning letters to the data sets I avoided using I and J as identifiers because I wanted to avoid any possibility of confusing the data set with my memos. My name begins with I and in the written German language I and J are written sometimes in a similar fashion so it would have been easy to confuse data with memos had I not take this precaution.

finally help to analyse my data. Colaizzi's phenomenological method (1978) of analysis therefore was the chosen approach. I decided to use this method as it provided me with a seven-step procedure, which seemed straightforward and took into account the phenomena under study. Following that procedure, I carefully read the whole data as a body and every single set as a body, followed by working through the women's conversations as a body and nurses' conversations as a body. This later procedure allowed a mapping of the issues related to the research questions. From there I wrote two accounts, one covering the women's expectations and their experiences, the other the nurses' view on women's needs and care provided during the early postnatal phase. At that stage, I decided to ask the participants to validate the preliminary findings. Therefore these two accounts were sent to participants; the one summarising women's conversations was sent to all ten participating women, the other with the nurses view was sent to fifteen nurses. The feedback received confirmed conformity with their experience and their present practice respectively.

Furthermore, the main themes arising from the two accounts were; 'adapting to the new situation', 'experiencing motherhood', 'creating a new family', 'professional support' and 'constructing a caring situation'. As an example, and to find out if these headings would serve for further analysis, I worked through Set A. This proved unsuccessful as it did not satisfactorily embrace the contextual influences. Therefore I decided to return to the original protocols with the research questions in mind and to extract significant statements out of ten transcripts. Those statements eventually laid the basis for the later used codes while working through each set separately. Up to that stage the process was expedited by the use of the computer software package, The Ethnograph v5.0. I then excerpted all the significant statements within the codes into a word document. From there I formulated a sentence or a phrase that rendered the meaning of the participants' descriptions, the fieldnotes and the entries in the documentation.

Step Four in Colaizzi's method (1978), which is organising clusters of themes according to the formulated meanings, proved to be less than satisfactory. This was mostly because of the variety of data sources I was using but also because of the massive amount of data. Moreover, I realised that contextual information important

to the subject under study was not appropriately covered with this method. Additionally, integrating the multiple perspectives of the participants was impossible as this method did not allow me to capture the dialectic nature which was inherent in my data. At this point I decided to drop Colaizzi's method of analysis. Nevertheless, I decided to use significant statements and the identified formulated meanings to write a fiction-like account from different viewpoints according to participants. The process of analysis up to Step Four, and further reading of Wolcott (1994; 1999), Lofland and Lofland (1995), Dey (1993) and Coffey (1999), helped with understanding the data and taking the analysis one step further. The "analytic movement from data to ideas" as Coffey (1999:137) calls this process, is often hard to demonstrate and difficult to describe. However, it involved much thinking, experimenting with the data and attempting to create a plausible account. Finally, I identified socio-cultural themes (Spradley, 1980) and designed a structure for the two data chapters. This eventually meant that I had to go back to the original protocols.

Identifying recurrent themes, Spradley (1980) suggests, can help to understand socio-cultural patterns. He provides the following definition for the term 'cultural theme':

A cultural theme is any principle recurrent in a number of domains, tacit or explicit, and serving as a relationship among subsystems of cultural meaning. (Spradley, 1980:141)

In Chapter Five I explore the theme 'being on a postnatal journey', which refers to the two intertwined journeys of first-time mothers while they are on the postnatal care unit whereas in Chapter Six the 'caring relationships' are explored. These two accounts are the "ultimate product of the analytic process" (Dey, 1993:237) and ought to illustrate experiences, events and circumstances of the subject under study.

To present the participants' experiences and to describe the day-to-day practice in the analysis I decided to use obtained data differently in the two data chapters. Observation as a means of data collection is limited and can produce questionable results as regards what has been seen or heard. The unreliability can be compounded by the complexity and unfamiliarity of the situation. For this reason I had also employed the method of conversations and the use of written material during the fieldwork process. The wide range of accounts provided multiple perspectives of the participating women and nurses. Documents formed a further basis for the analysis

presented in this study. I include the different data sources in Chapters Five and Six. Whilst conversational data are always quoted directly, observational data and at times texts from written material are worked into the text. That is not because I believe that conversations are versions of a more enhanced truth than my observations but they can be regarded as another “dimension of accountability” (Latimer, 1994:323). Such a decision was also supported by reading ethnographic studies in the field of nursing (Beil-Hildebrand, 2004; Latimer, 1994; Worth, 1999).

As mentioned in the summary of Chapter Two, the analysis is inspired by the theory of early motherhood by Barclay *et al.* (1997) and Swanson’s theory of caring (1991; 1993). The concept of liminality, defined by Turner (1967), serves an understanding to the dimension of time and space of first-time mother’s journey on the postnatal care unit.

A further discussion of the data analysis process is provided later in this chapter and in the concluding chapter of this thesis.

The Researcher as an Insider and an Outsider

From what has been said so far about my personal and professional background it is obvious that I was by no means a novice in the subject under study when I entered the postnatal care unit to do my fieldwork. Although I am not a mother myself, my personal background had provided me with ideas and beliefs about mothering, and as I listened to numerous accounts of mothers in my work I had a certain understanding of such experiences. My professional experience was rather more limited, since although I worked on a postnatal care unit, this was as a nursing student many years ago. Nevertheless when I began this study I had some understanding and knowledge of what postnatal care would involve as I had been working in the Clinics of Obstetrics and Gynaecology in the role of a Clinical Nurse Specialist. The name of the role can be rather misleading – this job was designed to support staff members in developing a reflective practice and quality care standards. My background in project management and organisational development largely determined this job description.

The degree of my involvement in care provision was made clear in the information which I provided to all potential participants before starting the fieldwork or when they became involved in it. However, it was also clear that I had a nursing background. Since research in nursing is still a novelty in Switzerland, familiarity with the role of researcher could not be expected from the participating nurses. Therefore I had to accept that they and also any other people on the unit would take me as a nurse in the first instance or as somebody who just hung about. Gerrish (1997) recommends a clear differentiation to the nursing staff, therefore I decided not to wear a nursing uniform but a badge, which identified me as researcher.

As an observer and as said earlier, moderately or passively involved, I was present on the postnatal unit for many hours over several months. This was challenging in keeping a balance between distance and involvement. Officially, as I was not providing care, I could step back when it was necessary to take the observer's position. However, there were situations when I was asked by nurses and a few times by women to help with minor tasks such as changing bed linen or holding the baby, which I usually willingly accepted. Only in a few situations did I refuse to act in a hands-on manner, when it would have prevented me focusing what was going on. I felt that such occasional involvements were appreciated by women and nurses and did not compromise my position as a researcher. Sometimes, I offered my help with baby care in the nursery or minor household tasks such as setting the breakfast table for the next morning. This was mainly to shorten long waiting times in between observational periods. In the end, all activities I engaged in were to mark membership of the nursing guild and to find acceptance in the eyes of nursing staff.

As a researcher I had to find a new self since one of my professional experiences was as a clinical teacher, though never in this setting. I had to learn to see things through a different lens. I struggled with that, especially in the beginning and later when I realised on one occasion that one experienced nurse addressed me as teacher.

The position of an outsider helped in countless situations by enabling me to take a distant position in relation to the subject under study. Conversely, when nurses persuaded me to wait outside since nothing special would be happening with the participating woman when they went in, the outsider position became a disadvantage

until I learned to be insistent about joining them anyway. A redefinition of the self and an acceptance of the importance of what I was doing on the unit helped me to become more determined to take responsibility for my work (Coffey, 1999).

Ethical Considerations

The ethical principles for research accepted by the Swiss Association of Nurses (SBK, 1998) were taken as guidelines for conducting this study. 'Respect for human dignity', 'beneficence', 'nonmaleficence' and 'justice' are the principles. The overriding maxim is to safeguard the rights of the participants under study (Spradley, 1980).

As described earlier in this chapter, ethical approval was sought and received from the authorised Ethics Committee prior to the commencement of the study. Permission was also given by the Chief Nursing Executive and the Clinical Director of the Clinic for Obstetrics at the study hospital.

All participants were informed about the aims and the procedure of the study and how the information obtained was to be treated. Recruiting women caused little problems; only two women withdrew right after the first contact. The recruiting process for the nurses however involved an element of coercion. If nurses refused to participate this could result in having to be reassigned to mothers who were not involved in the study. As mentioned earlier, three nurses refused to participate for obvious reasons. A few other nurses withheld their consent form and requested a personal conversation with me before giving consent. One nurse commented that she felt the need to participate because other nurses did and because her refusal might jeopardise the study. Another nurse was concerned that her professional conduct would be reported to the Nurse Manager. I could well understand their concerns as I also had recognised some peer pressure and I therefore invited them and the Nurse Manager for a discussion to clarify my view and to convey that voluntary participation was important. Subsequently, those nurses agreed to participate.

In a longitudinal study, voluntary participation remains a concern throughout all phases. Women and nurses were assured in advance that they would be asked again for consent before each observational period and conversation. I committed to that throughout the research process. This was particularly important as the women were in a vulnerable position and additionally, they were in a public place where the boundaries of privacy were already limited. Respect for people's dignity was the maxim during my observation as women and nurses were being exposed to a stranger. Time for reconsidering and the option for refusing or reconfirming their participation was therefore crucial. There was one woman who needed time to confirm the appointment for the final conversation. This was because of difficulties she had encountered in her relationship with the father of her baby. In the end, she approved, although I had given her an open option.

Justice was the overriding principle when informing women that participation or non-participation in the study would not affect care provision for them and their child. Similarly, nurses were assured that refusing to participate would not influence their employment. In preliminary discussions with nurses, I confirmed in the presence of the Nurse Manager that any misconduct would be discussed with them in person and not reported to the authority. There was one occasion when a midwifery student was about to harm herself by pricking her finger after applying a subcutaneous injection. I warned her in the room but discussed it later with her in a quiet place.

Some of the topics addressed in the conversations with women, especially their potential experience of motherhood, caused them to reflect on aspects of their relationships with their partners and mothers. This proved distressing for two women and I was challenged to manage those situations with reasonable expertise. My overriding principle was that of nonmaleficence. Within the same principle were some situations which occurred in conversations with nurses. By reflecting on applied care interventions there was some inappropriateness unveiled and this caused distress for the nurses.

Participants were ensured that all data obtained during conversations and observations as well as photocopied hospital records would be treated confidentially.

Tapes would be destroyed one year after completion of the study and transcribed data were stored in a locked filing cabinet. All participants were given a pseudonym. Nurses could voluntarily choose a name for themselves whereas for the women I assigned a first name according to the letter the data set was given.

Insight into the transcripts was offered to the participants but only a few made use of it. On the other hand and as mentioned in the section 'Pragmatic aspects of the analysis', an account of the preliminary finding was sent to all participating women and some nurses with the request to feed back how they received it. Six women and eight nurses replied with their personal comments. Dissemination of the study findings in professional literature and at conferences was mentioned in both consent forms.

Involvement in care provision on my part was not planned although I gladly accepted in helping with minor tasks in the course of my fieldwork. I considered it crucial not to be involved in conversations with women and nurses unless they made an attempt to integrate me. There were many occasions where I was addressed with personal or professional questions either by women or nurses. If it was not interfering with fulfilling nursing tasks I would of course engage with the person, but I also made clear that professional issues were in the first instance to be discussed either with the assigned nurse or the supervisor respectively.

The representation of the data if used carelessly would challenge the principle of justice and respect for the dignity of participants. Though it might contribute beneficially to the body of nursing knowledge, the vulnerability of the participants has to be treated with respect.

Language Issues

Language is an important instrument in research and needs to be dealt with cautiously. There are several issues of concern in this study.

Firstly, all conversations except one were carried out in the Swiss German language and transcribed into written standard German. This already involves a slight

translation since Swiss German is a spoken language only. One interview was conducted in English at the woman's request. Fieldnotes and documents were in written standard German.

Secondly, the translation into English occurred at different levels. Three transcripts of Set A were translated to give the supervisors some insight into the data. All remaining data sets were left in German. As I moved through the analysis I translated what I extracted from the body of data. A professional translator, whose first language is English, proofread the translated texts comparing them with the original protocols. Other texts included in this thesis, which were originally written in German, were translated by the above-mentioned translator.

Thirdly, translation bears the risk of changing and diluting meanings. With even two translations as described above, the authenticity of the original data is jeopardised as a one-to-one translation is never achievable.

Fourthly and as briefly raised in the introduction to this thesis, it is important to mention that in the Swiss German culture, people who are unknown to each other or who are in a formal relationship generally are addressed by their family names. Nevertheless, in this study although with some reluctance, I use first names for women as is the custom in English speaking countries. Likewise, I use first names for all the nurses and the students participating in this study. I also should mention that in recent years, it has become more and more the custom for nurses to introduce themselves by their family names and their professional qualification. In this postnatal setting this was the case for all staff members as well as for me as researcher, and the clientele adheres to this practice.

Trustworthiness

To engage in an ethnographic study means to commit oneself to the qualitative paradigm, therefore evaluation criteria should relate to that paradigm. Robson (1993) argues that traditional concepts of internal and external validity, reliability and objectivity in a positivist and post-positivist tradition are replaced by the criterion of

trustworthiness in a constructionist paradigm. The process of qualitative research needs to be rigorous and systematic and serious note has to be taken of the potential for bias in collecting, analysing and representing qualitative data. The documentation of the strategy as Holliday (2002:8) describes it is “showing its working”, and is similar to showing the method used to solve mathematical problems.

The four criteria referred to in constituting trustworthiness are: ‘credibility’, ‘transferability’, ‘dependability’, and ‘confirmability’, (Polit and Hungler, 1997; Robson, 1993).

Credibility is the intent “to demonstrate that the enquiry was carried out in a way which ensures that the subject of the enquiry is accurately identified and described” (Robson, 1993:403). In this study, a combination of data collection methods, continuous data analysis and a persistent focus on the phenomena under study ensured credibility. However, this study remains individualistic for the reason that the researcher and the field under study are not static components. Such fluidity has the potential to create inconsistency but the duration of the fieldwork provided an opportunity to focus on discrepancies and to reflect on them in further observation or interviews. Additionally, credibility has been enhanced by the involvement of my supervisors in discussing the data, the analysis process and the findings produced by the analysis.

Dependability goes along with credibility. By its own means it creates an audit trail that external reviewers can use to explore the process, judge decisions and understand what salient features in the context lead to decisions and interpretations made. In qualitative studies, methodological changes and shifts in construction are expected and such changes need to be tracked and trackable. As mentioned early in this chapter, the analysis of this study was an adventure – I went astray with my initial analysing method and had to reconsider my interpretive strategies.

Confirmability is the criterion on which can be assessed if the presented results are rooted in the context described, and the data obtained from the persons and the day-to-day activities in the setting. The focus is on the result itself and how this was processed. Auditing includes tracking back the data to their sources and testing if the

research narrative assembles the interpretations into a structurally coherent and corroborating whole.

Transferability of results from one setting to another is not so much the investigator's responsibility as it is that of the person who decides that results would be applicable in another context. Nevertheless, information of procedure, context and theoretical construct needs to be provided accurately and consistently and so that findings on which the reader can base his/her judgment can be presented persuasively (Robson, 1993).

The details discussed in this and the next three chapters provide the reader with the information necessary to begin evaluating the research according to the above-mentioned criteria. Whether the representation of the data meets the criteria of being readily understandable and useful for clinical nursing and policy can only be evaluated at the conclusion of the thesis.

Summary

The qualitative paradigm provides a methodology for understanding women's experience of becoming and being mothers in the early phase post-birth and for understanding theirs and the nurses' perception of postnatal care provision. Ethnography offers methods of collecting the most appropriate and actual data within the socio-cultural context. A combination of conversations, observations and documentary material strengthen the focus on the subject under study. The analysing procedure outlined shows the reflexive path taken to arrive at the representation of the socio-cultural themes. Before unveiling the interpretive findings, the socio-cultural context of this study is introduced in the subsequent chapter.

CHAPTER FOUR

THE CONTEXT

Introduction

As was indicated in Chapter Three, context is an important element of ethnographic research. Therefore, in this chapter, I provide a description of the hospital but more specifically of the postnatal unit where the study was conducted. In addition, a brief description of nursing education in Switzerland and the organisation of the nursing service in this study setting is given, along with standards and guidelines of postnatal care. Before discussing these issues as they relate to postnatal care, it is first important to describe the options women have for maternity care, the general organisation of the health care system and relevant information about health and family policies in Switzerland. This chapter concludes with a personal account of postnatal care experience.

Maternity Choices and Organisation of Health Care

Switzerland is a federation of 26 states and thus has some nationally delivered government programmes and others delivered at a state level. Although the central government is responsible for social and health insurance matters, health policy and service provision are authorised at state level (Zweifel, 2000). In the city where the study was conducted, women have four options for the birth of their baby. They can give birth in: a publicly funded general hospital that provides maternity services, such as the one where this study took place; a privately funded general hospital that

provides maternity services; a birthing centre devoted solely to the care of women throughout pregnancy, during and immediately following the birth of their babies; or women may choose to give birth at home. In 1990 the homebirth rate in Switzerland was one per cent (Ackermann-Liebrich *et al.*, 1996), and although no later data is available, it is reasonable to assume that women in Switzerland view birth in an institution as a standard procedure. This claim is supported by Ackermann-Liebrich *et al.* (1996:1313) who report that since the 1940s “hospital has been considered to be the safest place for women to give birth”.

Switzerland is praised for having an “extremely well developed health care system” (European Observatory on Health Care Systems, 2000:5). This is mirrored in the following maternity statistics. The infant mortality rate in 2001 was five out of 1000 live births and the maternal mortality ratio was five of every 100,000 live births (UNICEF, 2004⁴). Further, to secure a certain standard of health care provision, health insurance has been compulsory for every permanent resident since 1994. A cost-sharing scheme in case of illness includes a minimum fixed franchise payment per year (Theurl, 1999). However, according to Article 64, Paragraph 7 of the Federal Health Insurance Act, medical treatment and hospital based care for non-pathological pregnancy and childbirth are not bound to such a franchise. Each person is obliged to make a contract with a health insurance company for basic insurance coverage. Supplementary service can be contracted voluntarily and this would include, for example, staying in the private or semi-private sections of hospitals. Within a region, health insurance premium rates are the same for every insured person with the exception of a lower rate for children and young people between 18 and 25 years. There are variations in insurance rates across the different regions of the country. Low-income households receive a subsidy when “the premium for social and health insurance exceeds a limit in the order of eight to ten per cent of taxable income” (Zweifel, 2000:942).

Within the basic insurance scheme there is a definitive and binding catalogue of services although freedom to choose suppliers is restricted by law. For public hospitals, such as the one where the fieldwork for this study occurred, costs are paid

⁴ UNDP (2004) Human Development Reports, Switzerland (2003); retrieved http://www.undp.org/hdr2003/indicator/cty_f_CHE.html 05.02.04

partly by the insurance companies and partly by the state. Health insurance not only covers illness and its subsequent treatment costs, it also covers maternity issues such as prenatal, intrapartum, postnatal care and care for the baby. Insurers pay an amount per case and an additional amount for the number of days that women stay in the hospital (Protokoll des Zürcher Kantonsrates, 2000⁵). In contrast, the states do not pay any costs for women who choose to give birth in the home or in a private hospital, and because of this lack of subsidy, health insurance companies discourage these kinds of birth.

It is also important to consider demographic change in Switzerland over the last decades. Compared to thirty years ago, women now have more choice in family planning and are less economically dependent. As a result, many decide to have their first child much later. In 2000 the average age of women having their first baby was 30.1 years and 24 per cent of women at the age of 40 were still childless (BFS⁶). The total fertility rate per woman is currently 1.4 per cent (UNICEF, 2004⁷). There have also been changes surrounding women's integration into the workforce. In 1970, 28 per cent of women with children less than fifteen years old were working either full or part-time whereas in 2000, this applied to 68 per cent (BFS⁸). From this brief description of the demography and the health care system in Switzerland, it can be seen that women participating in this study would have minimal concerns regarding their ability to access health care in a hospital. They also would be likely to expect a low risk pregnancy, birth and postnatal experience, and a smooth re-integration into the workforce after a certain time.

⁵ Protokoll des Zürcher Kantonsrates (2000), Leistungsabbau bei Wöchnerinnen; KR-Nr. 7/2000; retrieved www.kantonsrat.zh.ch/internet/Protokolle/PDOC/PDOC2000/krp049.doc 05.02.04

⁶ BFS (Bundesamt fuer Statistik); Demographisches Porträt (2003) Volkszählung 2000; retrieved <http://www.bfs.admin.ch> 05.02.04

⁷ UNDP (2004) Human Development Reports, Switzerland (2003); retrieved http://www.undp.org/hdr2003/indicator/cty_f_CHE.html 05.02.04

⁸ Bundesamt fuer Statistik; Demographisches Porträt (2003) Volkszählung 2000; retrieved <http://www.bfs.admin.ch> 05.02.04

Maternity Leave Provisions in Switzerland

Since 1945 the Swiss Federal Government has had a constitutional mandate to provide maternity benefits but these benefits were limited to an obligation on all employers to provide only three weeks salary in the first year for women who gave birth. Over the last fifteen years there have been three attempts made by the Federal Government to pass legislation giving working women fourteen weeks of maternity leave at 80 per cent of their salary. All have been unsuccessful. It was only in September 2004 that a fourth attempt was successful after a majority of Swiss voters supported the proposed new law of a government-paid national maternity leave system (NZZ, 2004). Provision of this level of maternity leave has brought Switzerland into line with minimum Western European standards (European Observatory on Health Care Systems, 2000).

The lack of a country-wide extended maternity leave with benefits persisted for many years, and the phase of data collection for this study was within that time. From that point of view one could argue that the political claim that families are considered important remained a rhetorical farce. For example, Article 116 of the revised Swiss Federal Constitution⁹, which came into force in 2000, contains the following text: "In fulfilling its tasks, the Confederation shall take into account the needs of the family. It may support measures to protect the family. It shall institute a maternity insurance scheme". This lack of common ground at a federal level meant that maternity insurance was subject to social insurance policy, which varied in the different states. The state in which this study took place had a sixteen-week maternity leave for mothers returning to work and eight weeks if she left the job. The employer paid the costs of these maternity benefits. As has been noted earlier in this chapter the women in this study had a cultural expectation of ready access to health care and an expectation of an uncomplicated birth experience. They also lived in a state where the minimal maternity leave they could expect to receive was a period of eight-weeks paid leave with a maximum of sixteen paid weeks. Thus, all ten women

⁹ Die Schweizerische Bundesverfassung vom 18. April 1999; English version retrieved: www.lib.byu.edu/estu/eurodocs/swit/NewCHConst2.pdf translated by: Church, C.H. & Monnet, J. University of Kent at Canterbury

in the study would have had no immediate change in their financial status occurring simultaneously with the physical and emotional changes of the initial weeks following the birth of their baby. Since the last interview with each woman occurred within three weeks of the birth, it can be assumed that the concerns raised during this time frame are related more to the birth experience rather than being compounded by additional concerns regarding finances.

Length of Hospital Stay

All women in the study had a five day hospital stay, including the day of birth, guaranteed by their health insurance company. The duration of in-hospital care can be extended in case of health problems occurring. While this stay may seem long in comparison to the stays of shorter duration which are now the norm in Canada, the USA and UK¹⁰, only ten years ago the average stay in Switzerland was eight days¹¹. Early discharge, within 24 hours, of mother and child after a vaginal birth, (Bragg *et al.*, 1997) is clearly not a cultural expectation of Swiss women. In countries where early discharge occurs, an issue of concern arises regarding premature discharge of new mothers and follow-up programmes and community support are viewed as vital (Beck and Knoth, 2003). Because the Swiss health care system has a tradition of longer hospital stays, mothers and nurses do not yet have these concerns about premature discharge.

The current community services available to women in the city where the study took place are organised around the routine of a four to five day hospital stay, with an unstated assumption that the needs of the mother have largely been met by the time of discharge. Antenatal education about birth preparation is offered in maternity clinics but also by freelance midwives, whereas childcare issues are addressed in separate courses most likely offered by children's nurses employed by non-

¹⁰ OECD Health Data (2003) OECD Data Show Health Expenditures at an All-time High; retrieved http://www.oecd.org/document/39/0,2340,en_2649_201185_2789735_1_1_1_1,00.html 19.01.04

¹¹ Protokoll des Zürcher Kantonsrates (2000), Leistungsabbau bei Wöchnerinnen; KR-Nr. 7/2000; retrieved www.kantonsrat.zh.ch/internet/Protokolle/PDOC/PDOC2000/krp049.doc 05.02.04

government organisations. Postnatal support in the community is provided by parental clinics¹² which are well established in Switzerland and provide a basic service to women and parents with a child up to one year of age. The level of services can vary widely from one municipality to another. Parental clinics are mainly staffed by children's nurses with a special qualification in parental care, but some larger clinics have also appointed a midwife or a lactation consultant to complement the provision of their service. Non-government organisations often contribute financially to parental clinics, which are cost-free for parents. In case of perceived special needs or urgent support after discharge from hospital, nurses from a postnatal unit would contact the local parental clinic. This system of referral is only done with the agreement of the parents. Otherwise, women who are perceived to have 'normal' birth experiences must seek assistance from parental clinics themselves. Throughout Switzerland there is no obligatory home visiting scheme for new mothers. Women can seek additional support from midwives and lactation consultants in private practice and can claim the costs from their insurance companies. In extreme circumstances families can request a home help, which is partly supported by the insurance companies. Apart from these availabilities there are no other community services provided to new mothers and families. Although mothers and families are aware of these services, the tendency in Switzerland is for women to consult obstetricians, paediatricians or their family doctors regarding health problems.

To conclude, the provision of maternity care in Switzerland is largely institutionally based and the cultural expectations of women are framed in this context. Thus, women may have specific expectations of what they will learn about their own and the baby's care during their hospital stay, that might be different from women who give birth in a culture where earlier discharge is the norm. To further understand the context of these women's expectations it is important to understand the educational preparation and staffing levels of the nurses who provide care in the hospital setting. The next section of this chapter is devoted to this topic.

¹² Mütter- und Väterberatungsstellen

Nursing Education

As is the case throughout the world, Swiss nursing education has undergone a transformation in curricula. Until very recently all nursing education in Switzerland was delivered through hospital-based diploma programmes. Prior to 1967 a two-year diploma programme for a baby and postnatal nurse¹³ was common. This meant that the majority of nurses employed on postnatal units were specifically prepared for postnatal and nursery care. Even though the curriculum for the baby and postnatal nurse was changed in 1967 some schools continued their programme until 1995. This means even today and throughout Switzerland certified baby and postnatal nurses work on many postnatal units (Ludwig, 1994). After 1967 and prior to 1992 the most common nursing education programme was a three-year hospital based one with an emphasis on general, sick children's or psychiatric nursing. In 1992 further modification to nursing education occurred and a four-year diploma programme without specialisation was instituted. Nurses had the option of enrolling in either the three or four year programme. Midwifery education is also available for nurses and non-nurses in midwifery schools. Non-nurses enrol in a three-year programme and nurses in a two-year programme. Currently, the norm in the German speaking part of Switzerland is that in public hospitals, employed midwives are utilised in the delivery room and prenatal clinics and only in exception on the postnatal units. Midwives would only come to the postnatal unit on the request of the nurses and then only for consultation regarding specific midwifery questions. This division of labour is likely to create tension between the two professional groups as midwives take the responsibility for antenatal preparation of women but are not actively involved in postnatal care issues.

This brief overview demonstrates that there is a considerable range of education and associated skill sets among potential nurses who are employed on postnatal units. For the most part, nurses who are employed on postnatal units come from the diploma programmes in nursing. Older nurses are likely to be those who received education in the baby and postnatal nurse programme and/or the children's stream of the three-

¹³ Säuglings- und Wochenbettpflegerin

year diploma programme. Younger nurses may have received the four-year non-specialised education. This pattern held true for the nurses employed in the study. In addition, all of the baby and postnatal nurses had acquired additional qualifications. Women in this study, while not necessarily aware of the specific details of nursing education, would be aware of the cultural norm that midwives provide care in the delivery room and nurses provide care on the postnatal unit. While they might prefer continuity of care from the same caregiver throughout their hospitalisation, they are aware that this is not the norm. The next section will discuss organisation of maternity care in the hospital where the women in this study gave birth.

The General Hospital

In the following paragraphs the institutional setting of the study is explained to introduce the reader to the physical circumstances in which fieldwork took place. This General Hospital is the only public hospital in the city where this study took place. The 800-bed hospital serves as a teaching hospital for medical doctors, nurses and allied health professions and works together with Universities and other educational institutions although it is not a University Hospital *per se*. However, the structure and organisation of this hospital is comparable with other hospitals of similar size in the German speaking part of the country.

The women's clinic¹⁴ is one of twelve clinics and five institutes¹⁵ in the hospital and includes the disciplines of Gynaecology, Obstetrics, Reproductive Medicine and the Neonatal Care Unit, and inclusive in-patient and out-patient services. In one year, approximately 22,000 in-patients and an additional 44,000 outpatients are cared for at this General Hospital. In 2000 the number of children born at the hospital was 1162, which is 22.6 per cent of the total number of births registered in the region. The caesarean section rate was 21.5 per cent in that year. One can deduce from these numbers that while maternity care is important to the hospital it is not a high profile service. Women with uncomplicated pregnancies, as the women in this study were,

¹⁴ Here, I use the word 'clinic' instead of 'hospital' as a direct translation from the German term 'Klinik', specifically in this case it is Frauenklinik.

¹⁵ The name institute is given to units, which serve all the clinics such as the Institute of Radiology.

are referred to the hospital by their consultants. All expectant mothers who come in for labour are admitted directly to the labour-room unit. As the women enrolled in this study all had previously registered through an application process, they had no need for further administrative work to be done at the time of admission. The focus of care in the labour room was thus on their labour, and not on administrative detail.

Physical Layout of the Postnatal Care Unit

In this section the physical layout of the postnatal unit is described in order to assist the reader in understanding the context within which the nurses provide and the mothers receive care. The women's clinic is accommodated in one building of the 125-year-old complex, with major renovations being carried out some twenty years ago and a more recent redecoration to update the standard to that of hotel-style comfort. The postnatal unit, with twenty-seven beds in total, is divided into two units on different levels, floors three and four. Women's rooms overlook a park area and are located on one side of a long single corridor. On the opposite side of the corridor are the nursing offices and rooms for ancillaries and equipment storage. On each unit there is a relaxation room that women can use with their partners, and there are a few common places for spending time with visitors. This physical arrangement means that staff members not associated with direct care of the women are frequently in the same geographic area as nurses who provide the care. Privacy on the unit and a minimisation of noise due to activity in the corridor is maintained through a practice of keeping the doors of women's rooms closed at all times. This practice also means that when a nurse is attending to a woman and her baby, she cannot be available to any other woman outside the room unless called by an efficient buzzer system between the bedrooms and the nurses' office.

The women's rooms are homely and well appointed with furniture and the necessary technical equipment to ensure the safety and comfort of the women. There are single and three-bed rooms on the unit. In the three-bed rooms each bed has curtains that can be drawn to provide visual privacy. A fully equipped bathroom with a shower is standard in each room. In addition there is a toilet and shower off the corridor of each

unit. In some single and in a few three-bed rooms there is a changing table. Although babies generally are in the room with the mothers, there is a nursery room on each unit. The nursery has a glass door so that when babies are present they are visible to all staff members but no other security system is in operation.

The colour scheme of the rooms is subdued and consists of different shades of terracotta and yellow-beige. A modern electric bed, a mobile bedside drawer, a small mobile table, a built-in wardrobe, and a cot are available to the women. Each bed space has access to the call system, a telephone, a TV monitor, a radio and a night-light. Direct access to oxygen and air pressure is guaranteed. In each room there is a small dining table with assorted chairs. The overall physical set-up of the unit ensures that the majority of care and social interaction is carried out in the woman's room. Included here are basic activities such as eating, personal care, and care for the baby. For women in the three-bed rooms there is obviously more limited privacy than for those in single-bed rooms.

Organisation of Nursing Care

Since each country has its own system of nursing, and indeed individual hospitals organise care differently, it is important to describe the organisation of care at this General Hospital. Doing so provides a context for the reader to understand the routines experienced by the nurses and the women.

Organisation of time and staff on the unit

The working week in Switzerland is forty-two hours, which means that a nurse employed full-time would work five days a week with a daily working time of eight hours and twenty-four minutes. Obviously on a unit where there are new mothers and babies arriving and leaving the unit at differing times throughout the day, nurses have to be flexible in order to meet the needs of specific mothers and babies. Nonetheless, there is a semblance of a routine in the day-to-day practice. Some of the routines are the result of the reality that hospital care is provided over a 24-hour

period. The 24-hour period is organised around an early, late or night shift. The early shift starts at 7am with the handover from the night nurse and ends shortly before 4pm with handover to the late shift. The late shift starts at 2pm and ends at 11pm. The night nurses start their shift at 10.45pm and end at 7.15am. New admissions can be transferred from the delivery room of all times of the day and nurses have to be prepared for new job allocations. The Nurse Manager is in constant contact with the delivery room and is usually informed some time in advance when to expect a new admission. This allows the Nurse Manager to make the necessary organisational arrangements. Visitors have access to the unit from ten o'clock in the morning until eight o'clock in the evening. Partners are not treated as visitors and they are allowed to be on the unit around the clock.

How time is organised on the unit means that there is considerable 'traffic' over the course of 24 hours. In combination with the physical layout described earlier, this presents challenges for women and nursing staff in maintaining an atmosphere where intimate care is taking place and where women are learning new skills. In three-bed rooms there are bound to be more disruptions to women's care because of differing needs among those in the room. The hospital has tried to alleviate some of the logistical challenges of caring by providing an extra toilet and shower on each unit. The recreation area, described earlier, also alleviates congestion in women's rooms. For example, women can use this separate area when there are large numbers of visitors in a three-bed room, or when additional privacy is needed.

Visiting times influence the workflow on the unit to some extent, however nursing tasks are very determined. Examinations of mother and baby, as well as other caring tasks, are carried out routinely. Eating times also influence nurses' workflow. Whereas babies' feeding times are unpredictable, women's meals are timetabled, though with considerable flexibility. Breakfast is offered as a buffet but all other meals are serviced by tray. Breakfast time is from 7.30 to 9.00 am and it is set up in a secluded area at one end of the corridor. Women are expected to take their babies with them but often they ask the nurse to take care of them while they eat. Lunch and supper are served in the women's room. If women do not eat when the trays are delivered, the meal can be reheated, and served when the woman desires. Partners are permitted to eat at the hospital if they request it, paying a minimal fee.

The type of nursing care delivery is organised as continuous women allocation. On average, during the early or late shift, one nurse cares for four to six women and their babies. At night one diploma nurse, a student nurse and an auxiliary nurse are on duty on each level of the unit. The Nurse Manager plans the women's allocation for the day in advance and reviews it again before the early and the late shifts commence. This enables her to make adjustments when new women have been transferred from the labour unit to the postnatal unit during the night or when there is unanticipated staff absence. The nurses discuss the activities with the women and work out a daily schedule as far as it is predictable. This involves placing an emphasis on the individual and tailoring care to the women's particular needs. Monitoring the woman and the baby, personal care of both, rest times, breastfeeding and the meals, influence the structure of the shifts. Ordered treatment and examinations, visits from doctors and other health care professionals usually take place during the early shift.

As this brief description indicates, the daily routine is very much determined by the woman and baby's needs. Babies sleep and feed at unpredictable times and therefore physical logistics such as flexible meal arrangements help ensure that the mothers receive adequate nutrition. This flexibility also facilitates opportunities for families to engage in mealtimes together and thus helps create family time. Active engagement in determining a plan for the day also assists in ensuring that the routine of the unit adapts to the woman as much as possible, rather than the woman conforming to the routine of the unit.

Organisation of handover on the unit

The process for handover on the unit varies depending on whether it is an early, late or night shift. The early morning handover is done in the nurses' office. In contrast, the late shift handover routinely occurs at the women's bedsides. At the early handover the Nurse Manager provides general information about the daily routine on the unit or scheduled educational lessons. During the overlapping time at late handover, planned educational sessions or short team meetings occur. When handover occurs at the bedside, as on the late shift, it is the early shift nurse's task to

take the lead in the discussion but both nurses are responsible for ensuring continuity of care. In correlation with women and their partners, the nurses evaluate care, assess care needs and adjust plans as necessary, during handover at the bedside. Women are expected to engage in the conversation but the extent of involvement depends on nurses as well as women and partners. When handover involves nursing and midwifery students a supervisor always accompanies them. When handover occurs in the nurse's office it is done through a written report. Because there is an overlap on the shift, the nurses from the previous shift are present to clarify any confusion or queries arising from the written report. For specific questions the nurses from both shifts visit the woman to discuss the care together.

Organisation of work on the unit

After late handover, the work load is structured by women and babies' needs and the schedule is less affected by determined tasks than during the early shift. Spare time can be used for teaching childcare, for more extensive conversations with women and partners, as well as monitoring students. Although the two levels of the postnatal units are staffed separately, the nurses in charge of each level support and help each other during the late and night shifts. During daytime there are always senior nurses available on each level. During a night shift if the nurses require extra assistance they call the delivery room, contact the nurse in charge on the Neonatal Special Care Unit or the doctor on night duty. Breaks during night shift are planned according to the workload. During the day and the late shift, nurses have two official breaks for coffee and for a meal. Coffee breaks are on the unit whereas for the main meal there is a thirty-minute break usually taken in the hospital's restaurant. During busier times it is not unusual for nurses to forgo their break and order their meals to be delivered to the unit.

Obstetricians and one paediatrician are in charge of the medical diagnoses and therapy. Apart from one standardised examination before discharge, the obstetrician only consults women at the request of the nurses during the time on the unit. There are no daily and standardised doctors' rounds on this unit but some consultants visit women and this more so with privately or semi-privately insured women. The

paediatrician examines the baby within the first twelve hours after birth and again before discharge. In general doctors plan their visits and examinations to suit themselves, which can be inconvenient for women and their babies when they have not yet an established feeding and sleeping routine. On weekdays, the Physiotherapy Department provides postnatal exercise classes and individual physiotherapy at the request of the nurses. Dieticians and social workers are consulted in case of special needs identified by the nurses. Some referrals have to be discussed with the doctors before being passed on to specialists. There are also ministers of religion from different congregations affiliated to the hospital who can be called upon by women. A standardised reporting system to the parental clinics ensures that women are registered for a visit in their community settings. If a woman is not in agreement and does not want the parental clinic informed she is requested to sign a refusal form.

The Unit Policy

Quality assurance is mandatory under the Law of Health Insurance. However, Beck and Knoth (2003) criticise the absence of national guidelines for maternity care in Switzerland. This has inevitably led to different standards of care provision across the country and made hospitals develop their own standards of care. However, this Clinic of Obstetrics was certified as a Baby-Friendly Hospital in 1995, which means that care on the postnatal unit followed the “Ten steps to successful breastfeeding” recommended by UNICEF. Furthermore postnatal care is based on the following quality standards, which were developed by the nursing staff of the postnatal care unit under my supervision at the time I was employed there and they were in use during the time of the study. The guidelines are presented below so that the reader has an understanding of the information available for appraising how the actual practice conforms to the guidelines.

- Exchange of information between parents and nursing staff; The nurses responsible ensure a level of information that allows the parents to cope with the new situation;¹⁶

¹⁶ Informationsaustausch Eltern-Pflegende; Die Bezugspflegende gewährt einen Informationsstand, dass sich die Eltern in der neuen Situation zurechtfinden können.

- Rooming-in practice in the postnatal unit; Rooming-in practice in postnatal care means that mother and baby are placed in the same room and cared for by the same members of staff. In addition to the spatial conditions, rooming-in also means that nursing staff promote the parent-child bonding;¹⁷
- Advice and support with breastfeeding; Pregnant women and new mothers are given information, advice and support with breastfeeding in accordance with the “Ten steps to successful breastfeeding” (UNICEF/WHO, 1992). Women who cannot breastfeed or do not wish to can be sure of empathetic advice. In terms of building up the mother-child relationship and in terms of the baby’s nutrition, they can count on our support;¹⁸
- Handing over at the bedside: Application of the nursing process in collaboration with the woman; The continuity and quality of care is ensured by involving the woman;¹⁹
- Collection of information and nursing assessment: The relevant nursing information has been noted, a nursing assessment has taken place and these form the basis for nursing diagnoses and care plans.²⁰

As is the case with all formal guidelines, there is variation in how the guidelines are carried out and this will become evident in the data chapters of this thesis. Informal guidelines complementary to the written guidelines always exist in any organisation and this postnatal care unit is no exception. In a personal conversation the Nurse Manager summarised them as follows:

- Rest and recovery from the physical strains of pregnancy and the birth experience;
- Assessment of the physiological adaptation of mother and baby and prevention of problems;
- Support of the mother and baby during the period of adjustment;

¹⁷ Rooming-in Pflege auf der Wochenbettstation; Unter Rooming-in-Pflege auf Wochenbettstationen ist eine gemeinsame Unterbringung und Betreuung von Mutter und Neugeborenem zu verstehen. Neben diesen räumlichen Bedingungen beinhaltet Rooming-In ausserdem die Förderung der Eltern-Kind-Beziehung durch das Pflegepersonal.

¹⁸ Beratung und Unterstützung beim Stillen; Schwangere und Wöchnerinnen werden bezüglich Ernährung des Kindes nach den 10 Schritten zum erfolgreichen Stillen (UNICEF/WHO, 1992) informiert, beraten und unterstützt. Frauen die nicht stillen können oder möchten, dürfen einer einfühlsamen Beratung gewiss sein. Beim Aufbau der Mutter-Kind-Beziehung und bei der Ernährung des Neugeborenen können sie auf unsere Unterstützung zählen.

¹⁹ Pflegevisite: Bearbeitung des Pflegeprozesses in Zusammenarbeit mit der Frau; Die Kontinuität und Qualität der Pflege ist gewährleistet unter Einbezug der Frau

²⁰ Informationssammlung und pflegerische Einschätzung: Die für die Pflege relevanten Informationen sind registriert, die pflegerische Einschätzung ist erfolgt und diese bilden die Ausgangslage für die Pflegediagnose und die Planung der Interventionen.

- Education of the mother in aspects relative to personal and baby care;
- Completion of specific prophylactic or screening procedures and assessment of safety and security (potentially violent home situations, drug abuse).

Contrasting Context of Birth in Switzerland

Now that I have presented the current day context of this structure of birth in Switzerland, it is important to frame the discussion in terms of the private and professional experiences I have had with birth and the postnatal phase. Disclosure of such information is consistent with what Morse and Field (1995) and Wolcott (1999) discuss. It is an important attribute of ethnography. My childhood experiences are probably the most influential in forming my views surrounding childbirth and early postnatal care. As the third of eight children, I had the opportunity to experience how our family grew larger. Mother gave birth to all of us at home. During early childhood, and as long as we were of no active help to my mother, we were sent away 'on holiday' shortly before my mother gave birth. We usually stayed with relatives until my mother could cope with all the tasks of a newborn and the older siblings. Our grandma and a home help were usually in the house to support my mother with the household chores. Later, when my oldest sister and I were old enough to help we stayed at home. I remember in particular the birth of my two youngest sisters. The community midwife was a frequent guest in our home. The family doctor only attended one birth however, I have no recollection why this was necessary.

During the actual birth we children were not allowed in our mother's bedroom but we were present in the house and curious with all our senses, about what was going on in her room. It was a great mystery, although as we grew older we started to comprehend what was going on. I remember my sister Cécile's birth since this was right after Christmas and she was born during the night. My father had promised to wake us up as soon as the baby was born, and he did. We were allowed to go into my mother's room to admire our new sister before we went back to sleep.

My early childhood experiences left me with a lasting impression of birth as something that takes place within the living environment of a family. Though I later learned what hard work it was for my mother and how exhausted she became when she was older, I still remember the happiness in our house. All of us truly enjoyed looking after the new baby, which of course had certain limits. My mother breastfed all of us but later when the babies began taking the bottle or solid food we were given responsibility for such tasks. Throughout my teenage years, and this was common in the village where I grew up, I had the opportunity to be the childminder in a family with three children. This took place during the time the mother was pregnant with her fourth child. The birth took place at home and we were all assembled in her bedroom afterwards to celebrate the arrival of the new baby.

Years later, during my nursing education when I did my placement on the postnatal unit, the first birth I attended was the birth of twin boys. Experiencing the cold atmosphere of this delivery was a rather shocking experience. The vivid contrast between the institutional experience of birth and birth at home stayed with me. As noted in Chapter Three, when I had the opportunity to work with nurses on a postnatal unit my curiosity was whetted regarding the structure and subsequent care offered to first-time mothers, further leading me to conduct this research.

Summary

Throughout this chapter I have provided the reader with contextual information about the study setting. The description of the general organisation of the health care system and information about health and family policy in Switzerland adds to a wider understanding of the context in which postnatal care is provided. In addition, an outlay of patterns of nursing education, and the standards and guidelines of care at the postnatal care unit serves as the backdrop for conveying the results of this study. The next two chapters discuss the journey women make as they experience becoming and being mothers, their experience of postnatal care while they are in hospital. Relationships between women and nurses will be examined from both perspectives, that of the women and the nurses.

CHAPTER FIVE

BEING ON POSTNATAL JOURNEYS

Introduction

In this chapter and the following, the intention is to uncover the complexity of the nature and structure of postnatal care and the factors influencing provision of care. This chapter will present two different journeys of first-time mothers. One journey illustrates the mode of becoming and being a mother as this was described and reviewed in Chapter One by following the theory of early motherhood (Barclay *et al.*, 1997). The other journey, which is embedded in the constructed world of the hospital, describes the first-time mothers' passage through the postnatal unit. This passage is liminal in the sense that it has a beginning and an end. However, in the liminality of the postnatal care setting the two journeys are intertwined. Mainly it is nurses who provide care to first-time mothers and go along with them on their journeys. In this respect, women's needs are addressed in this chapter as they experience being a mother while establishing a relationship with their babies and their partners, and while learning to care for their babies and themselves. The day-to-day care practice on the postnatal unit will be examined according to Swanson's theory of caring (1991; 1993) as introduced in Chapter Two. Further inspiration for this investigation is provided by the theoretical stance of construction of a subjective reality in this social world.

The journey on the postnatal unit for the first-time mothers sets off with 'entering the scene' where they make themselves familiar with the setting. 'Being in there' is the next stage where women are settling in on the unit and try to find their way. This

journey resumes as women are ‘anticipating life with a baby’ as they are embarking on a new and different life at home.

This interplay between first-time mothers and nurses was seen through “my eyes/I” (Kondo, 1990:3) as a woman, a nurse and a researcher while collecting data on the postnatal unit. In this and the following chapter, the themes ‘being on postnatal journeys’ and ‘caring relationships’ are presented as they were elaborated through the analysing process. Through the use of direct quotations from all data sources it is intended to bring alive the women’s journeys and the relational interplay with the nurses on the postnatal unit. The quotations are coded with reference to the particular sets, the number or letter of the transcripts as well as the line numbers. A few quotations will be cited more than once within the themes as they entail different issues and so that they can be viewed from various perspectives. In this study all women and nurses are called by a pseudonymous first name. To avoid confusion, nurses’ names are complemented by their title on every first naming in the respective paragraph or section.

Entering the Scene

This postnatal unit is an institutionalised setting featuring a structure and the day-to-day practice particular to this field. The institution ‘postnatal unit’ has been created through the professionals in this scene and has been historically developed over many decades. Hospitals are designated locations in which illness is the dominating issue and the course of action is cure and care. In this hospitalised structure, technical procedures, routines and a set timetable are characteristics which control a process such as childbearing and the provision of care. Within this structure, there are nurses and other professionals, for example, medical doctors, physiotherapists, social workers, dieticians, paramedics, administrators and cleaners. The nurses’ professional autonomy and ethic of service qualifies them to manage the day-to-day practice particular to this field. As a result, knowledge, self-direction and familiarity with the setting allow them to be able to exert professional control over the well-being and care of first-time mothers.

In the postnatal setting women and babies are the prime receivers of care. Women entering this scene after birth are in an individual transition process in which social status is lost and gained. The very recent experience of birth and the introduction to a new social role makes them highly vulnerable. These women are novice mothers and are just about to discover the uniqueness of a relationship with their new-born babies. Although this phase after birth is considered common enough and the literature reveals that most childbearing women are healthy, the role of a patient is assigned to them within this hospital setting.

At the moment of entering the scene, women are left to the care of the employed nurses on the postnatal unit. However, the ritual of handing over is controlled by midwives. As a result, the scene is dominated by two professional groups and through that a clear division of the caring process of these women becomes apparent. Women transit from the labour unit to the postnatal unit, hence from midwifery to nursing care. In relation to working out the birth experience the different groups of professionals in the two locations are significant, denoting a division of care.

The activity of admitting woman and baby to the postnatal unit involves a short introduction. This procedure of incorporating women into the unit's routine can be seen as a decontextualisation to the outer world which is, as Wolf (1988) reasons, made explicit by rituals. Since this initial phase of being a mother occurs away from the familiar environment of women's homes, such adaptation puts additional pressure on women. The woman is given a designated space in a room and is introduced to the other women there. All women in this study were allocated to a three-bed room. The admission is structured by a conventionalised procedure concerning, for example, information about conduct, food and the unit's schedule. At the outset, a physical assessment of woman and baby is done at their bedside and at the same time information is transmitted to women and obtained from them.

Care takes place within this setting and this is significant as the roles of the woman and the nurse are shaped by clear social expectations and designated role behaviour. A major expectation is that nurses assess women's needs, and that they plan, initiate and evaluate care interventions in response to the negotiated requirements, whilst also involved in routine care, educational and administrative tasks. Women are

expected to conform to the unit's routine, to behave in a certain way and to move on. Within this liminal space, they are required to learn the tasks concerning caring for themselves and for their babies. Women have a certain pre-conceived understanding of institutions such as hospitals and of the conduct of a receiver of care, either through previous experience or possibly by observing other people. Entering that scene requires orientation and negotiation for the women to determine their individual conduct. What an institution and the professionals within it are expecting from the women is conveyed to them through different channels, both overtly and covertly. Written material informs women about the unit's schedule and standard information and questions from nurses indicate what is acceptable within that setting. To mention a few more indicators, nonverbal behaviour of staff members and the flow of work transmit information to women, and shape their understanding of what behaviour is expected.

The following section represents how the introduction of the women to this environment progresses. Furthermore it reviews the first-time mothers' recent experience of birth and the nurses' responses to it. This is important as it constitutes a bridge between the two settings: labour unit and postnatal unit. Moreover this section focuses on how women familiarise themselves with this setting and how they settle in.

Realising what has been happening

Realisation of the process of becoming a mother, and the impact the birth of their child has on women's lives, becomes manifest in this early postnatal phase (Barclay *et al.*, 1997). Realising is multifaceted as it embraces orientation of the self within the experience, and it is influenced by the expectations women had, their birth experience and the volume of tasks that have to be learned with a baby. Inherent is the recognition that "this is my baby and I have to care for it" (Rogan *et al.*, 1997:881). In theory, realising is not a one-off episode since first-time mothers develop their understanding of becoming and being a mother over time and in a cyclical manner (Barclay *et al.*, 1997; Rogan *et al.*, 1997). On the level of personal experience birth marks entry into motherhood although women will have prepared

themselves theoretically for their new role during pregnancy. Realising is made apparent through the bodily presence of the baby and the changes in the woman's body. The overwhelming experience of birth is at the forefront and everything revolves around the baby. Another level of realising is the understanding that something is over and a new phase in daily life and lived experience is about to start. Although realising remains ongoing, the transfer from the labour unit to the postnatal unit can accentuate the process as this marks a step from being a childbearing woman to being a woman with a child. As shown in the following section, women take their impressions of birth with them from the labour unit and these are central during the days on the postnatal unit.

Impressions of birth

Having the baby in her arms as Eleonora, one participating woman in my study said, "made me forget the strains of birth at least for the time being" (EF/68-71). Niven and Murphy-Black (2000) conclude from a literature review about labour pain that such pain is not easily forgotten and it can be recalled though the accuracy of the recollection is debated. Nevertheless there is obviously some mystery in the situation when women hold and see their babies and express reward and fascination. Kirstin, another participant, was amazed at, "how nature made babies so sweet that looking at her made me forget all the suffering and worries" (K2/871-876) she endured during the labour process. She had an understanding of how birth would be for her but the real experience of labour was beyond her imagination. She described it as, "horrible, a really horrible experience":

Kirstin: I wanted that, I wanted to try and have a normal birth, that was only when they realised it really wasn't going to happen. Her head was in a strange position and she might get distressed, that's when they said well, let's have a caesarean and when they actually said that, I had enough.

Irena: So it was the right decision at this point.

Kirstin: Yes definitely, I was still, I was really upset, hmmm, to have a caesarean, when it actually happened. I thought oh, I was really upset about it, but then afterwards, when I was back to normal again, I thought, it doesn't matter, it was time now, I was absolutely so tired, I don't think I would have the energy to push her out. I was really absolutely, totally finished, so that was probably just as well (...)

Irena: Well, you never have thought you would have a caesarean section before?

Kirstin: hmmm, I didn't think so, I thought I would have a normal delivery, I really did and I wanted one as well, I did, but obviously the drugs, but not a caesarean, I didn't think, no but then, really it's just a question of, you know, delivering your baby in the safest possible way and in the end of the day, you got your baby, so it doesn't matter, not for me anyway. (K2/776-844)

Kirstin's account emphasises birth as an ambivalent experience and a disappointment because she did not perform as expected. After a low-risk pregnancy it was expected that she would give birth vaginally to a healthy baby. Although understanding the rationale for a caesarean birth she felt she had lost control over an action with which she had expected to cope well. As Barclay *et al.* (1997:722) describe, realising "depends on women being able to accept their birth experience". A traumatic birth creates a demand to constantly recall the experience, it influences women's recovery and hence determines emotional well-being (Barclay *et al.*, 1997; Niven, 1992). This is relevant to postnatal care as women need time to cope with that experience. The first day I observed Kirstin, Nurse Barbara was allocated to her. How Barbara responded to Kirstin is demonstrated in the following extract from my fieldnotes:

Barbara is organising everything around ambulation agreeing on the time she would help Kirstin to get out of bed. After supper the woman gave a tired and sad impression, had tears in her eyes but said she didn't know why she was crying. She expressed worries about the baby's well-being because the baby was burping frequently but was quiet and seemed to be sleeping. Barbara checked the baby's vital signs, informed the woman that everything was okay. Although Barbara's words were meant to reassure the woman I could observe that Kirstin did not calm down. Barbara repeatedly confirmed that everything was okay. Barbara's attempt to be sympathetic and understanding seemed not to convince Kirstin. (KF/93-113)

In the subsequent conversation with Barbara I asked her to explain how she perceived the situation with Kirstin:

Barbara: Well, I've noticed that she's simply very tired, exhausted, that's how I perceived her at first sight and then I realised that she was very anxious. Hmmm, the whole situation has just not, hmmm, hasn't sunk in, that's my impression, that's what I could sense, and again this evening when she started to cry again I became aware of it and she said she didn't know why she was crying. I got the impression it's connected with anxiety because the baby won't drink and sleeps all the time, so she thinks there is something wrong with her. But it's probably just the last straw with the whole thing ... I've realised she probably wasn't prepared for a caesarean, what she had on her mind was a vaginal birth. (K3/13-38)

This example demonstrates coping with a stressful experience in process. Lazarus and Folkman (1984:141) define coping as:

constantly changing cognitive and behavioural efforts to manage specific external and/or internal demands that are appraised as taxing or exceeding the resources of the person.

With the statement “it hasn’t sunk in” Barbara expresses that Kirstin is far from realising what has been going on, and what impact it will have on her life. Although Barbara reasoned Kirstin’s emotional behaviour was connected with the distressing labour process her course of action was not related to that. Instead of encouraging Kirstin to talk about her experience the nurse made attempts to convince her that everything with the baby was alright. As a result, the nurse’s behaviour did not comply with Kirstin’s understanding of her nurturing role. In this situation the basic knowledge of coping, and related interventions, were not apparent. Barclay *et al.* (1997) reason that repeatedly telling the birth story could be a way of helping first-time mothers to resolve stress and to move on.

The example of Kirstin and Barbara also indicates the importance of debriefing as a structured psychological intervention. Debriefing as described by Armstrong *et al.* (1991) (cited in Robbins, 1999:267) is a four-stage model including, “disclosure of events, exploring cognitions and emotions, exploring coping strategies and a termination phase”. Systematic debriefing after childbirth has scarcely been researched and Alexander (1998) suggests clarification of the term, purpose and value. Although in a randomised controlled trial, women confirmed the helpfulness of midwife-led debriefing, it did not maintain the promise of improving maternal health after caesarean birth (Small *et al.*, 2000). As Steele and Beadle (2003) conclude, confusion surrounding postnatal debriefing continues. They suggest that:

effective postnatal care should recognise the importance of psychological well-being of women. This involves opportunities throughout the period of contact for the woman to describe her experiences, discuss her feelings, and receive information and a rationale for the care she receives. Such care may help to identify those who require referral to professionals with specialist mental health knowledge. (Steele and Beadle, 2003:135)

Hence, a caring approach which would allow ‘being with’ could facilitate effective coping although Kaplan (1983) argues that effective coping with difficult life events or traumatic experiences does not only depend on care interventions. It also varies, depending on the belief system, appraisal of stressors and resources women bring into this situation. Unresolved traumatic experiences might influence decisions about subsequent pregnancies. Hillan (1992) reports on her investigation of women after a caesarean birth. One fifth of the participants were not properly informed or were at

best inadequately informed about the process of labour, the reason for the subsequent operative birth and the possible management of subsequent pregnancies. She recommends ensuring that those subjects are discussed before women are discharged. Olin and Faxelid (2003) support that recommendation but conclude from their quantitative inquiry of Swedish mothers (n=251) and fathers (n=235) that the best time for a talk would be up to day three post-birth.

Time is a factor that needs consideration as women differ in the time needed in coping with their experiences. This aspect is brought to light in Hanna's version of her birth experience. She gave birth vaginally but she described her experience as difficult. She missed out of giving a full account of her labour, and the process of realising what had happened to her was still going on three weeks post-birth. Additionally her way of coping differed from Kirstin's. Her story gives insight into how she thought and felt about it in retrospect:

Hanna: Well today, I see it a bit more relaxed than I did at first. At first, I couldn't even think about it, or speak about it. As I was saying, the whole thing, was too extreme, well the entire experience because I didn't, as I said I had somehow a different idea also in terms of support through midwives and things. So I found it pretty disappointing and well, also because the midwife was incredibly overburdened and quite frequently she had to leave and this was during stages when I really was in need of her support, I desperately needed someone to tell me how to breathe and what to do and things. It was with every contraction that I was desperate that somebody would talk me through. And this is why, I have this feeling and because she wasn't there the contractions somehow, yes they were just contractions and didn't really have any effect. As I just said it didn't progress a great deal, yes, yes and you know pain and distress, yes. But beside that I see it more relaxed now and I, we can talk about it now, my partner and I, because it is important for him to talk about. It also was very extreme for him, yes to see me suffer like that or ...

Irena: Well, this is a very different experience, or a new experience in your partnership, to see that.

Hanna: Yes, well, certainly, absolutely and he really needed to talk about it, but as I just said, in the beginning it didn't go well and then Nurse X said we could go over it with the midwife and discuss it. But at the onset, those first days, it was impossible and I also felt that I had to set it aside for a bit and, and I must, I must concentrate on the baby and other things have priority, and well, labour and birth, I'll have to think about them later.

Irena: Fine, but would it have been helpful for you to have gone back to the midwife at some point or at least to have made contact with her?

Hanna: Well yes, maybe, because I have the impression I had little information about the stages of labour. I know the different stages but I was never sure where I was and what phase I was in, because it was so extreme and – because yes, also what kind of medication I had and so on. (H2/133-205)

Hanna had great trust in the hospital service from what she had learned at the introduction to the Clinic of Obstetrics. Her ideal image of birth as she said in our

initial conversation was “to be free to choose, to decide what one wants and to be my own boss” (H1/605-610). Essentially those expectations were not fulfilled. Another critical aspect to consider is that her partner was present throughout the entire labour process. According to research results reported by Niven (1992), it is the couple who need support in coping with their experience, and different ways of supporting women and partners will need to be negotiated. It is noteworthy that Olin and Fakelid (2003) provide the same evidence in their research when they state that first-time fathers want to talk about childbirth with professionals. Of their sample, 59 per cent of first-time fathers wished to engage in a conversation. Although Hanna’s partner was frequently present during the postnatal phase I could not see that the nurses made any attempt to involve him in a conversation about how he felt. Although notes had been made about discussing the birth issue with the assisting midwife, nothing was said concerning her partner.

Similarly to Hanna, two other women, Eleonora and Carol mentioned their partners’ struggle with the birth experience in our final conversation. According to the care documentation, Eleonora never mentioned it and she did not have a talk with the assisting midwife nor with other personnel from the labour unit. While still in hospital, Carol raised the subject of her birth experience frequently and asked the nurse to organise a talk with the obstetrician and the midwife. She wished to include her partner but when Carol eventually met the obstetrician for a talk her partner did not attend. Without giving further reasons she said he was not available at the set time of that meeting.

Exclusion of partners in discussions of a highly emotional issue such as the birth experience raises the question of social control over a procedure determined by the professionals within the hospital structure. The women in this study became dependent on the midwife and obstetrician during the birth process as we have seen with Hanna. From her account, it becomes obvious that she was not in a position to ask for explanations nor was her partner. The midwife’s presence and absence during labour restrained her from asking questions and according to Hanna, there was no further information provided by the midwife. An instant reflection on procedure and conduct would have been essential for that couple. A brief talk before being transferred to the postnatal unit might have encouraged Hanna to contact the midwife

later for a more comprehensive talk. As Olin and Faxelid (2003) reason, this would support a more effective way of coping with a difficult birth experience. Within this care structure an ad-hoc meeting proves difficult as the midwives are not available to women after discharge from the labour unit. This argument provides evidence that geographical distance, but also the practice of distancing midwives from postnatal care provision, contributes to inconsistency of care, hence depleting quality care.

Attempts by midwives to create a partnership in their collaboration with women, did not feature in Hanna's account. Additionally, Hanna's example echoes what Green *et al.* (1990) described as an important outcome in their study. Information and control were responsible for how women felt postnatally and antenatal expectations influenced their well-being. It is of importance to note that women in their study were not necessarily dissatisfied with everything. This is confirmed by Hanna insofar as she was positive about the provision of postnatal care.

The following excerpt is from Diana's final conversation, which was held seventeen days after her caesarean birth. Her partner Marco was occasionally present during our conversation and joined in at times. Considering the course of the labour, Diana's understanding of her birth process was complemented by Marco's perception of provision of information by the male obstetrician. Diana had a long and exhausting labour and finally the baby's deteriorating condition indicated a caesarean birth:

Marco: Then he said to us, hmmm ... caesarean, he would recommend a caesarean. All right I thought something is not quite right if he's suggesting that. He's not the kind of person who just says that, just like that and then I started worrying about what could be wrong. We didn't know exactly – well, yes we realised something wasn't going quite right but we didn't know what exactly was going on. (...) I have to say, it was the right thing to do, on the whole. I then thought okay, I was very grateful and I said this to the doctor afterwards, that he reacted immediately, that everything went well und they really made a big effort. Mind you as they all say it's their duty but I think, well that's just how I felt, really, that it happened so suddenly and went very quickly and well, and hmmm, how can I put this ... yes it is, at that moment it was maybe, hmm there was fear there. (...)

Diana: Afterwards, yes afterwards the doctor came and explained, well the cardiac sounds, for example that the cardiac sounds were not good and I didn't know that before. Well I had realised they were looking at the monitor but ...

Marco: Well he said that, he said that the cardiac sounds were weak, yes he said ...

Diana: Did he say that – I don't remember ...

Marco: Yes, I asked him what that meant and he then explained the baby would be ready but was too weak to contribute in any way.

Diana: I see, I've – maybe this was between two contractions, I didn't get that.

Marco: I did ask him yes, and that's what he said and then I said, OK, fair enough, if he thinks a caesarean is the right thing ... (D2/1121-1243)

Marco's view reflects satisfactory information but Diana had not understood the reason for a caesarean at that particular time. My examination of this situation is based on shared decision-making. The idea behind that concept is that everyone should be kept informed and people should feel free to ask until they have an understanding of the procedure and can give consent. However, in life threatening situations a slightly different approach needs to be utilized. From this and Hanna's account of her experience in the labour room quoted earlier it appears that this was not the case and this indicates a dependent relationship. Nevertheless it is noteworthy that women accept themselves as patients, as denoted by their withdrawn behaviour in the situation. Even their partners tune in by not requesting their rights. An analytical stance on the role of woman as patient will follow later as this issue also features in the postnatal setting.

Evidence in the care documentation

All these interview extracts give evidence of vivid memories about labour and birth and many were rather dramatic. However, some women related to their experiences positively and this was borne out by our final conversations at home. As mentioned previously, birth experience definitely plays a crucial part during the early postnatal phase. It therefore should be expected that details of the birth process are recorded in the care documentation. However, Fleming (1998:13) recounts that "midwifery knowledge does not lend itself to documentation". By verifying the care records from the participating women the appropriateness of entries proved to be a critical point.

Although a standard question on the nurses' interview schedule, not all of the ten care records revealed information about the childbearing experience. Most entries were brief and rather factual, abstract language reduced to physical aspects or length of labour. Frequent notes were made about the physical aftermath of birth such as the condition of the episiotomy, involution of the uterus, ambulation problems and the responding interventions. These kinds of entries appeared repeatedly and in all the

ten women's documentation. Specific facets of childbirth experience were mentioned in Kirstin's documentation:

The birth was awful for her, even though she was prepared. She says she's disappointed with herself because she needed a caesarean even if she is aware she did her best. Had an abortion at the age of 21. (KD/10)

In the following days, it was mentioned several times that Kirstin was in tears. One nurse remarked that she had explained possible reasons for her upset feelings. Diana's dramatic experience was summarised as follows:

Pregnancy: the first trimester rather difficult because of two spontaneous abortions. She wasn't really looking forward to it, had little hope, best was just not to think about being pregnant. At the same time she felt guilty toward her unborn baby. Labour: everything went so quick, was anxious about the baby - relief as she heard her first cry. (DD/10-19)

The emotional experience of birth scarcely features. An entry in Britta's documentation informs about her positive birth experience and on her third day in hospital her notes state:

She's come to terms with it (BD/13-15).

Flavia's record was the only one in the ten to reveal information about the presence of her partner during childbirth and how this helped her:

Birth: very happy to have an epidural, beneficial in the third stage, made the experience pleasant. Her partner was of great support to her. (FD/8-12)

Entries in several of the women's documentation reveal that the opportunity of a meeting with the midwife to discuss the birth experience was raised in the assessment interview. According to the notes, Carol was the only woman who benefited from that. However, Kirstin told me that she had a lengthy talk with the obstetrician about her birth, a fact that did not feature in her record.

What materialises from these types of written information is an emphasis on the physical aspect of childbirth evident in the postnatal phase and the resulting care interventions, whereas the highly emotional impact of childbirth is rarely mentioned. Given the geographical organisation of the clinic, as described in Chapter Four, the spatial division of care does not favour continuity of care. Moreover, it promotes a fragmented approach and emotions are sacrificed. Documentation is the only maintained evidence of the caring process and could bridge the gap but what surfaces proves inadequate. However, documentation does reveal the complexity of postnatal

care. Written reports which adequately represent the women's condition would enhance communication, and therefore support, towards continuity of care. These two issues will be addressed in the next chapter. According to the unit's guidelines, documentation of care is a statutory requirement although no explicit recommendation of its quality is apparent in these policy papers.

As mentioned in Chapter Two, postnatal care is accorded the least importance and understanding of the three segments in maternity. In this respect, a lack of appropriate and clear structured information in the documentation can lead to a lowering of standards for a profession. Written material is one way to provide evidence useful for a better acknowledgment of this type of care. Professionals are responsible for defining the standard of care and maintaining it. Such attempts would also assist in bridging the gap between the labour unit and postnatal unit.

Adapting to the setting

Being on the threshold of the postnatal unit women are introduced to a different structure of organisation compared to the labour unit. Women are aware that only limited time can be made available to them by staff, however they have to quickly orientate themselves to the setting. This implies that adapting to the setting is defined by the structure and by the respective professionals. For most women, this was their first experience in the role of a care recipient. While routines and procedures can help to organise and structure a life world, at the same time these can restrict freedom and coerce people into certain behaviours.

Locating the self

The women's adjustment to the unit's routine is facilitated by their understanding of the experience and how to handle the new situation. However, a known frame of reference is temporarily lost as women are in a new and strange environment (Pizzini, 1989) and the definition of self in this social context needs alteration. One aspect of socialisation to a temporary role within that setting was to find out what personal behaviour was accepted and what was not accepted. As I observed, Liana

closely watched the nurses' reactions and in our final conversation, she concluded that it was alright that her partner lay down with her on her bed:

Liana: I got the impression my partner felt at home. When he came in, he put his bag down, took his shoes off and lay down beside me on the bed, but I thought that was lovely. Then if a nurse came in and she had a smile on her face, well then I thought, okay, they tolerate it.

Irena: Hmm.

Liana: Well I did definitely enjoy that. And anyway we're like that, we're very affectionate with each other. I don't know ... but it's the same at home. (...)

Irena: Did you ever sense that this was not alright, something you shouldn't do?

Liana: Not at all, I was rather surprised that not one nurse came and objected. Well I always thought, no, you can't do this, you know? But when a nurse came and she smiled at me, okay I thought, after that, yes it's not that bad, and that's why I never said anything to him. No, no-one ever came and told us you can't do that. (L2/458-500)

Pizzini (1989) reasons that feeling uncertain or even anxious when entering a hospital is a normal reaction. Such senses become obvious from Liana's statement as she carefully considers whether her partner's behaviour is appropriate in a hospital. She enjoys the physical closeness and intimacy and observes nurses' reactions to his conduct in search of approval. Midwifery student Simona interpreted Liana's partner's behaviour as feeling comfortable and her reading corresponds with the woman's interpretation of the nurses' reaction:

Simona: And I don't believe he was uncomfortable because when he came, he always lay down beside her and – and ate with her or he had the baby in his arms. (L5/505-510)

Simona approved of this behaviour but more important is the way Liana orientates herself within the setting. To comply with requested behaviour seems essential to Liana as she seems anxious to fit into the system. Locating the self in an unknown setting starts before entering this scene. In the initial conversation, Alicia expressed acceptance of certain regulations regarding the unit's routine and child care. As long as her private sphere and her opinion were respected she would accept regulations, not really knowing what these would entail. The way she saw this before and after birth is expressed in the following quotations:

Irena: But what kind of support do you think you'll need or rather what are they [the nurses] going to take over for you?

Alicia: I think it depends a bit on the situation, if things should turn out more difficult and I don't know what to do, I'd like to have someone to take over, you know, the same sort of things that you [Alicia is referring to me, who she saw as a representative of the postnatal care unit] offer, so you get a chance to get a good night's sleep, you know - I

could really see myself - you know, wanting that. But if you feel all right and things are going well, I don't think you want too many people to interfere.

Irena: Hmmm, I see, so that you get your own space.

Alicia: I think it's important to be able to say how much you want. (A1/629-652)

In our final conversation, Alicia commented on the unit's regulations as follows:

Alicia: Somehow there are regulations you have to follow such as how to give a bath, how to do baby care, but honestly everything with little effort. Well I think, it was quite positive that you just use water and nothing else really, yes very natural, but hmmm, if there were too many regulations, then I often thought, well yes, I'll do it my way [laughs] (A2/374-383).

What Alicia emphasises in this statement is that she could agree with some childcare issues but at the same time she also had some different ideas. Alicia respected what the nurses taught her in terms of childcare and she approved of it for the time being. Simultaneously, she was aware she would adapt certain things to her liking when she was at home, therefore she did not enter a debate with the nurse. Finally, it influenced her decision to leave the hospital on day four after birth. It becomes apparent in this statement that the days on the postnatal unit were liminal and it also indicates routinised care, which is in contrast to a women-centred care approach.

To provide adequate and individually tailored education in childcare issues, the basis is information and an individualised assessment of such issues. At the time of the above-mentioned incident no assessment interview was documented, hence care was based on assumptions and routine. In Tarkka and Paunonen's study (1996b) women wished more individual guidance in childcare, and as Hillan (1992:277) reports routinised care is "insufficiently flexible and sensitive to allow the best possible support of the mother". Care interventions which take women's individual needs into consideration are more likely to feature within a devolved organisational structure. However, and as Adams and Bond (2003a; 2003b) reason, caring processes and outcomes largely depend on culture, nurses' attitude and their competence.

As previously mentioned, women locate themselves in the postnatal setting. Eleonora feared a dilemma because of her background as a nurse. She pictured a busy unit with a shortage of staff and little time for women and babies. Before birth when we were talking about her expectations, the main concerns she had were "privacy and to be respected as a mother" (E1/1162). There was an indication that she would fall back into the role of a nurse as we will see in the following statement:

Eleonora: A colleague of mine works in that hospital, and she told me that they have a lot of births in June and July. I thought, oh no, I know how busy units like that can be and I don't want to be involved in it, it's not my problem and - and well I really, or maybe this is a requirement to myself that I really see myself as a patient, not as, not that I have the feeling I have to, hmm to do interventions, which they should and it's not that I do them myself only because I know how to do them. I would really like to fully indulge in it as the other mothers can do who don't have a nursing background. Yes, to be spoiled, yes. (E1/1284-1303)

While observing Eleonora and her allocated nurses, there were a few signs I related to such expected behaviour. One issue was that her baby was hypoglycaemic. In our final conversation I raised that subject:

Irena: Hmmm, something else that interests me, you're a nurse and you said you didn't want to be seen or treated as a nurse. How did that go for you?

Eleonora: Um ... I've realised that, hmmm of my own accord, well how can I put this, I put myself in that situation, like for example 'baby at risk', I didn't ask because I assumed they thought I'm a nurse anyway and so I should know what it means (...)

Irena: And what about the nurses, did you get the impression they treated you as a nurse?

Eleonora: They, I don't know if it was deliberate, but they tried to involve me at handing-over, you know when they are talking about issues, they'd usually say, well, Eleonora, why don't you tell us how your day's been, and I always replied, no, I'll leave that to you and so they did and I was happy. I didn't want, yes I didn't want to give details about the day, I thought no, they should do it. (E2/1104-1180)

Student nurse Naomi was allocated to Eleonora during my first observational period during a late shift. She was aware of Eleonora's professional background and when I asked her, she commented on that situation as follows:

Naomi: ... well what I realised - well what I could sense is, it was not all that tragic for her. I don't know if they had explained why the baby was at risk or what a 'baby at risk' means, I don't know - but it also may have something to do that she has worked on a postnatal unit and maybe she still knows what it means. (E3/367-378)

The above interview excerpts give insight into role expectations and role performance. The institution seems to impose certain role behaviour on women and this is made clear by Eleonora. Apparently Naomi perceived Eleonora as a nurse and therefore she expected she had the knowledge to understand the diagnosis of her baby. Another aspect brought to light was that Eleonora saw herself as a patient and this became very obvious when she described the passivity in her behaviour, the idea that 'They should do it'. The conferred image of a patient is submissive and receiving and it corresponds with the view that at times of vulnerability the usual freedom to act as a person is diminished. The postnatal period as Rubin (1975:1684)

states, “is the most vulnerable period” and therefore women could be retaining a dependent role.

As stated in the guidelines, nurses have to inform women about measures of their condition and to offer them the opportunity to participate in the process of handing-over. An attempt to involve Eleonora is understood by her to disregard her rights as a patient to lie back. Obviously Eleonora lacked information about the procedure of handing-over and her contribution to it. Therefore she took the invitation to talk about her well-being as a duty instead of a right. From a caring point of view, it could be argued that ‘doing for’ as a caring process is expected whereas nurses considered involving women in tasks was appropriate and beneficial because it allowed them to express their own views. ‘Enabling’ the woman to present her ideas involves informing her adequately about aims and procedures first.

One of the vital concepts brought out in the preceding section is information. ‘Enabling’ the women to orientate themselves in the setting and to acquire an informed understanding for subsequent decisions requires a certain amount of information. The unit with its routine has to be introduced to the women. Liana reflected on that as follows:

Liana: The last two days, I had a nurse on the late shift who was very competent, that’s how I sensed it – and from her I got lots of information which I didn’t have in the beginning, and I should have had in the beginning so I could’ve benefited from it. Well, those were things which were left out. (...) It was so busy and she was, well I figured it out when she admitted another woman to our room. She was explaining everything to her as it were and suddenly I understood it all too and thought ah, ah and a lot of things just became clear. (L2/591-617)

This participating woman, although transferred to the unit in the early morning, a time when the unit is usually well staffed, missed out on information in the beginning. Although conveying information is a described procedure, it takes diverse paths determined by women and nurses, by the workload and by the time women are admitted to the unit. Information is closely linked to control and power and this is in the hands of the nurses. According to the unit’s guidelines, nurses deliver all the basic information at the onset of hospitalisation, with the aim of familiarising women with the setting and to establish a frame of reference. Information not only helps women to locate themselves and to be in control, but more importantly it influences emotional well-being and determines the outcome of care.

Statements presented in the above section highlight the power nurses possess but also the power women ascribe to them. This puts nurses in a position to control issues such as information, routine, behaviour and compliance. Women, therefore, are challenged to negotiate their own space to find themselves within the defined structure. Such effort demands energy and at the same time women in this study are constrained by their adaptive process to their new role.

Getting rest

In the journey to motherhood, time and space are important elements for mother, father and baby to get to know each other. The unit's guidelines state that nurses create an ideal milieu in order to support adaptation after birth, and to reduce stress for babies and parents. The structure of the daily routine is hugely influential as well as the professional and personal competence and cooperation of all the professionals. Or, more literally, the actual creation of space is limited. In this postnatal unit as described in Chapter Four, space for women is reduced to the designated bed and to one room where they can sit in private with their partners, as well a few common rooms to stay with visitors. This restricts women to spending most of their time in or around their beds and this is the space where mother and father are continuing to create their relationship with the baby. Time is an issue on the postnatal unit as it is to a great extent regulated by the hospital structure, the nursing and medical procedures and the needs of the babies. Time slots are scarce but well appreciated as we see in the following data excerpt:

Alicia: Hmm, well ... firstly, it was really nice that they left me in peace on the first day, I definitely noticed that. So everything suddenly came on the second day – everybody wanted something, but this [being left in peace] was very important to me and that's real wisdom on their part, they were very tuned in to my needs. And during the night as well, hmm I arrived around 2 o'clock on the unit and it was lovely. There was a nurse and she, yes, she didn't say much and was very reassuring, just said a few things such as I should get up, hmm ... yes, I felt in very good hands. (A2/431-449)

Trust in the nurse is made explicit here, which allows the woman to relax and to engage with the baby. Formally assessing the situation and 'knowing' what is essential in this initial phase forms an understanding, which allows time and space for the woman. On the other hand this space is essential for the baby to develop trust

in her/his mother. In an environment where a woman trusts the nurse she can fully concentrate on herself and her baby. As a result this initial time together is crucial to forming an identity. A sense of identity as Erikson (1968:105) suggests, “arises out of the encounter of maternal person and small infant, an encounter which is one of mutual trustworthiness and mutual recognition”. Alicia’s statement “that’s real wisdom” expresses the importance of that moment. Shedding light on that expression from a caring perspective, the nurse on duty that night understood the situation, had the experience and knowledge to assess woman and baby immediately and could convey her belief that they were fine, which allowed the woman to relax.

A contrasting experience is reflected in Eleonora’s situation. Although time and space were given in the understanding of student nurse Naomi, Eleonora’s account was rather different. How the first few hours were seen by nurse and woman is shown in the following extracts:

Naomi: Well, one focus is definitely to allow the woman to rest a bit, to let her digest what was happening, also to let her try and get some sleep in between the checks. (E3/36-41)

Eleonora illuminates the issues around rest and sleep as follows:

Eleonora: Yes, I was very tired, simply exhausted and tired, but yes, it was from the labour and I couldn’t bear it. Usually I’m the kind of person who likes to go to the disco and all that but at that time I just...I only wanted to be left in peace and quiet, just this, yes, (...) I felt like there were hundreds of people in my room and it was... I was being smothered by them or something. (E2/898-915) (...) I barely could cope with it and when I did manage to fall asleep, the other woman had to extract milk, that was one thing and if she wasn’t extracting milk then the third woman went to the toilet and slammed the door. Well I thought this is too much, but then I thought, yes, okay maybe this is just the first night. (E2/805-814)

Inability to determine the flow of things in such an environment is a central issue in this statement. This is significant as the women are strangers and at the same time vulnerable and therefore not able to control the situation. Considering the context, Eleonora’s account gives evidence of a busy three-bedded room, occupied by women from different ethnic backgrounds. Her need to rest and to have a quiet time with the baby, though respected and supported by the nurse, was interfered with by the business of other women and the routine of the nurses. Individualised care can only be set in context. Though a niche was created from the nurse’s point of view, the woman felt disrupted. Some women in Tarkka and Paunonen’s study (1996b) support this view as they felt disrupted by other people, mainly visitors but also by

the nurses' routine. The environment influences women's well-being considerably, and without bearing that in mind individualised care will not feature.

Attention was drawn by Nurse Carla to creating a niche in the care situation with Britta.

Carla: Well, with the aim of giving her time to rest and time for her family, her new family, her partner and her baby, that they really have space for themselves as a unit ... hmm, yes and that I did involve the father as well (...) and something that she signalled very clearly was that she wanted it quiet in her room early in the evening so she could sleep. Her need for rest, to do justice to it as much as that was possible in that three-bed room.

Irena: Yes, she was quite clear about that, she wanted to have a proper sleep, yes, she had already expressed that in the afternoon at hand-over.

Carla: Peace and security, those were the two, well...

Irena: Well ... and do you think you were able to do those things justice on that shift?

Carla: Only partially ... I noticed it was unsettled in the beginning, there were so many visitors. I wasn't sure if I should raise that issue or protect her. (...) well I would have liked to have given her more peace and time, I mean with her family. (B3/268-323)

Such a reflection shows recognition of the woman's need for rest and sleep. The importance of being together as a unit, as well as the impact the context had on the many different people responsible for the atmosphere in this room, was recognised. Carla concluded the section quoted above by saying: "I would have liked to have been more confident in this situation" (B3/326-328). It appears that the nurse had recognised the woman/family's needs. She admits that she was not in full command, hence she did not act as the woman's advocate. Advocacy is only possible on the basis of recognising women's needs, which requires 'being with' in the first instance. In such low-risk situations as described above, Hewitt (2002) argues nurses would be able to empower women but only if they are empowered themselves.

By entering the scene, women are confronted with the routine of a strange setting while they are coping with the recent and powerful experience of giving birth to their baby. The transfer from the labour unit to the postnatal unit marks a step in the transition process but it also signifies fragmentation of care provision. Women's individual journeys require intimacy, time and space to rest and to negotiate the new role and the relationship with the baby and the partner. However, there appears to be a detrimental effect on the transition process as women are challenged to adapt to the contextual circumstances.

Being in There

During these days on the postnatal unit, women are confronted with numerous new issues and coping with them is a challenge while still overwhelmed by the experience of becoming a mother. Negotiating time and space for recuperation and for the new family is a challenge as they are bound into a given structure. On this second step during their journey on the postnatal unit, they start to realise the impact that being a mother has on them.

Realising what is needed

In this process women realise that they are growing into another way of life and at the same time they are adapting to the needs of their babies. Aspects of realising are the novelty of the situation and the amount that has to be learned with a baby (Barclay *et al.*, 1997) as we see in the following two quotes:

Britta: Not really – to imagine it truly – well I thought it would be hard – that you'd always be a bit busy, but no, to imagine it truly ... (B2/141-145)

Hanna: It was hard work in the beginning and there was always something. (H2/11-18)

In these two statements women are emphasising childcare issues and they expressed demand and surprise. Prenatally, they were aware that the experience would be something totally new but the impact it would have on them was unexpected. It is interesting that this newness was mainly related to childcare and not to self-care issues as the following excerpt shows:

Hanna: Yes, I must say (...) I had misjudged the time it would take with breastfeeding and so on, yes I definitely underestimated it, that it's actually a really... that it's a long ritual with all the preparation, with the actual feed and then – we did it so that we'd change the nappy in between feeds because we realised that afterwards he drank better, and then feeding again after changing his nappy, and this really became a long procedure with the compresses afterwards. I must say you're constantly at it, you don't have much time to rest. You really don't have much quiet time. I did think I would have time to read a bit or something like that, but I didn't even have time to listen to the radio or to, let's say rest – well I had quiet times, hmm yes in the sense that I wasn't disturbed all the time or anything. From that point of view I had my quiet times but not in the sense that there was a moment of just nothing, really nothing that had to be done or time to relax a bit, you always had to keep at it.

Irena: Yes

Hanna: And with the baby, I mean with nappy changing it just takes so much longer in the beginning and with childcare until you, yes you've got the hang of it how it works, yes. (H2/621-649)

In this early time on the postnatal unit, women are introduced to childcare as this is a prominent issue on the nurses' agenda and a major concern for women. Although childcare is only one aspect of the reality of being a mother, it is a new and challenging task and occupies their mind and time to a great extent. It is emotionally taxing and as Sethi (1995) concludes in her study, women feel excited, uncertain, fearful and sometimes frustrated in learning to care for their babies. Women feel 'unready' as they feel unprepared for the tasks (Barclay *et al.*, 1997) but to some extent, they expected they would have to learn a great deal. Even for Flavia, who had attended a childcare course, caring for her baby was a different experience:

Irena: Referring to what you knew before and what you learned at the hospital, how did these come together at the end?

Flavia: Hmm, well I'd the feeling in these courses, everything was – somehow it didn't touch me – well how can I put this, I did take it in as knowledge but not really personally, it wasn't really related to me. Well now I've realised that somehow I couldn't ... or maybe even because I couldn't imagine how it would be to have a baby, for ever. And at the hospital everything – everything seemed to be new to me, or simply, it became more real and yes, hmm. Well I'm not sure if I would recommend a childcare course to someone else. It's probably more to get to know the issues but not, well this at least was for me, it was not necessarily to – really to learn something you could use afterwards. That's how it was for me at least, anyway.

Irena: That's what you'd say now, with hindsight.

Flavia: Yes exactly but at that time, I did find it very good to get in touch with things, to see what I have to expect. But I didn't really take it seriously or I just didn't feel that affected by it, hmm. But of course it's good, simply to know about everything. But there was so much, she would talk about everything imaginable, nutrition at the age of two or three and so on. I don't remember everything but somehow it was a great hotchpotch. (F2/1196-1245) (...) Well, the antenatal course, it was rather, well I got the feeling I could take more from that.

Irena: Was it closer to you?

Flavia: Maybe, and it was shorter and more often, yes ...

Irena: Your ability to take it in...

Flavia: Well it probably was more immediate, birth is first, everything else comes afterwards. Maybe you distance yourself a bit too, yes. (F2/1291-1307)

Not all women in the present study attended antenatal classes and only a few were participating in childcare lessons. Previous experience in childcare as far as women in this study are concerned has been gained through childhood experience, contact with relatives or friends who had children, or from professional involvement.

Preparation for childcare was not the women's main focus and those who attended courses were not utterly enthusiastic about it as Barclay *et al.* (1997) confirm. Antenatal classes with a focus on birthing issues were rated more helpful in the sense that they would allow women scope for personal development. Flavia's statement about antenatal preparation is well supported in the literature as it is shown in Chapter Two. In general, women in this study admitted they felt unprepared for the reality of being a mother. As a result, acquiring knowledge and skills remained a central aspect postnatally.

Self-care issues

The above statements draw attention to one important issue in postnatal care which is childcare, a very dominant concern in these early days on the postnatal unit. As I observed over the months in the field, women and nurses focused strongly on that issue. The enduring presence of the baby and her or his needs become prominent, particularly in terms of breastfeeding and related issues. According to Cudmore (1997), the focus turns away from the self to the child in the early days post-birth, but Rubin (1984) states that women need caring attention to be able to care for the baby. Similarly, Fichardt *et al.* (1994) argue that women's needs should be given priority as they can only attend to their babies when their own needs are fulfilled. The authors conclude that childcare issues should be taught during the initial time, which later allows women to focus on themselves. Such an argument could justify childcare being at the top of the nurses' agenda in the early days after birth. However, self-care issues remain important. According to responses from participating women, they experienced physical discomfort and emotional turmoil, which require distinct attention. The following data excerpts aim to bring out some of the women's needs and how nurses attended to them. The quotations below, from Alicia's data set, elucidate how a pain issue was handled:

Alicia: And hmm, as the time went by ... yes I just had the feeling, I often said I'm in quite a lot of pain – like that – yes and this was just – oh yes, everybody's in pain. Yes and this was just taken as something that's part of the deal. I think everything revolves around the baby, somehow, this, but what bothers women is just so normal. They have their problems in those days. Well this is what I noticed because I repeatedly said, look, I'm in pain, but that was ... yeah ... that's just how it is.

Irena: It didn't have the same priority as something related to the child.

Alicia: Yes.

Irena: Yes, hmm – how did this pain develop?

Alicia: Yes – I did – well those are really only minor things – but ...

Irena: Well still ...

Alicia: When we had this final talk I did ask if I could take this bottle [to rinse the perineum/episiotomy] home with me and – hmm, and nurse Leila [Larissa's supervisor] said no, that won't be necessary and I wouldn't need it at home. And that caused me a lot of problems for the first days at home, I almost went crazy with the burning pain and itchiness and hmm – and then I thought, somehow yes, they didn't really deal with that. But it's – well with hindsight I think, yes the first couple of days are really difficult, and no-one really gets round that, you know? (A2/450-497)

Larissa, the allocated student nurse shed light on that issue from her point of view:

Larissa: ... I feel she held herself back. I told her to give me a shout whenever she needed some ice on her vaginal tear, whenever she felt pain and wanted another ice pack, but she never did. ... So, I don't know if she didn't dare, or if she was really holding herself back. And so it was only when we talked, during the assessment interview that I found out that she had that pain and that she wasn't feeling all that well. ... So I asked her once again whether she wanted some ice, then she said yes, that might be good. (A3/380-397)

As a result, the pain did not get the attention Alicia thought adequate and this caused disappointment. Her individual experience was not taken into consideration, hence the interventions remained on a routine level. Larissa on the other hand perceived this woman as not making clear her needs so she could deal with them properly. Paradoxically, several entries in the documentation give evidence of the fact that Alicia mentioned discomfort with the episiotomy. Cold compresses were applied but no evidence was provided about the effect of this intervention (AD/36-57). In this respect, the two messages remain contradictory in terms of understanding and appropriate response.

Similarly, the following example taken from Diana's data set indicates a differing perception of needs and the response to them. It was when I was observing Nurse Angela working with Diana and two other women in the room that another nurse came and asked if those women wanted to attend postnatal exercise classes. Angela's immediate response was no but Diana and another woman spontaneously said yes they would like to go, if not today, then tomorrow (DF/224-232). In the subsequent conversation with Angela, I addressed that incident:

Angela: Well I noticed that she – well and this was in the morning, she made no attempt to come with me when I went to change the nappy or hmm, or the same with other

things. She did not say, okay I'd like to come with you or – no. That's one thing I noticed but then at the same time, when I was talking about pelvic exercise classes with the other woman, she then said, she would like to go tomorrow too. That came quite clear – hmm. (D4/17-30)

What becomes clear from this statement is that Angela's perception slightly differed to what I had heard. Yet, Diana on the other hand gave an unprompted explanation to this situation, which shows her viewpoint:

Diana: On Thursday I went to the pelvic exercise classes, half an hour. Before that I wasn't aware [that she needed some physical distance] and when I was there, in a way I really forgot her [the baby] and when I got back, hmm, it was only when I got back to the room that I realised how good this half hour had done me. I went about things, yes – with new vigour. And I was really happy to go again on Friday for this half hour, it really did me good. (D2/711-723)

The woman expressed her need to have time on her own and to get some distance from the baby. This might well explain why Diana made no attempt to go with the nurse to the nursery earlier that morning. Without inquiring about the woman's needs and the rationale behind her decisions, the nurse's interpretation of Diana's interest in contributing to childcare is that of reluctance. What surfaces here is that a rapport was not established between the woman and the nurse. Further issues of relationship will be discussed in Chapter Six.

Apparent from both above accounts is that lack of information can be misleading. 'Knowing' women's needs was inadequately explored and in both caring situations the assessment interview was missing when the event occurred. By checking the documentation, it was verified that the timing of the assessment interviews with the women in this study proved to be very different. Moreover, not all ten documentation sets had an entry regarding such an interview despite the statutory requirement that every woman is assessed thoroughly. Additionally, the entries showed differing qualities of such interviews. An assessment is intended for the collection and interpretation of information, and to plan interventions when considering the woman's perspective and her needs. Indeed, assessing women's needs is not a singular action at the beginning of their stay. As situations and emotions change, continuous engagement with interactions is of central importance. Barker (1997:6) defines assessment as:

the decision-making process, based upon the collection of relevant information, using a formal set of ethical criteria, which contributes to an overall evaluation of a person and his circumstances.

However Alicia and Diana articulate different types of needs, which are in Bradshaw's typology (1972) felt and expressed needs. Here the common ground in the descriptions is the diverse judgement of those needs by the nurses, which result in controversial understanding and a deficient provision of care. Looking behind that, there appears to be a hypothesis of what first-time mothers need in their early days and how they ought to present themselves. What Alicia brings to the fore is that there is something in this phase all women have to go through when she says: "They have their problems in those days" and she complements it with the following:

Alicia: Yes, they – I mean, they brought cold compresses and things – everything that you can do - I wasn't entirely left on my own, no, but that's what I noticed a bit. Otherwise they were so caring in there. (A2/515-521)

Sethi (1995) supports the notion of routinised care by saying that health care professionals consider standardised care as sufficient for first-time mothers and intend to practise with the assumption that postnatal processes are universal. Transition, as described in Chapter One, is an individual experience unique to every woman and prompts different reactions. Within this process, different needs feature, as Diana illustrated. She was desperate for a short break from her baby, and her statement suggested that focusing on her self was important. Martell (2001) confirms that such times might be as helpful as centring attention on teaching childcare. Unless assessing women's needs and ensuring that care interventions correspond with their experiences of the transitional process, individualised care remains rhetorical.

Learning to care

As mentioned previously, one emphasis in this early phase post-birth is on childcare issues. As stated earlier, the women in this study were overwhelmed by what was coming their way. Most participating women were eager to learn as much and as quickly as possible. Handling the baby and providing physical care are things to learn but another very important aspect is getting to know the baby.

Getting to know the baby

A mediating factor which facilitates the transition into motherhood is the nature of the baby and how the mother reacts to the baby's behaviour (Barclay *et al.*, 1997).

One woman describes how the baby's crying challenged her:

Eleonora: Whenever I became nervous about his crying, it was even more, well I just didn't know what to do then. But now I've realised, yes, one thing after another and - yes, it's simply this tranquillity. (...) Yes, I'm getting to know myself from another perspective, that I didn't think about before. (E2/341-353)

Women's expectations concerning their children are likely to have been derived from their previous experiences with children. However, women imagine their ideal baby during pregnancy and develop expectations (Lewis, 1979) and after birth they are confronted with their real baby. This can either confirm or clash with their expectations, influencing how women cope with distressing situations concerning baby's behaviour and success in breastfeeding. This inevitably leads to getting to know the self. Nurse Ladina was involved when Carol and her partner were anxiously dealing with their crying baby. Calming the baby proved difficult for the parents but Ladina recommended going to a quiet place where she was finally able to soothe him. The nurse reflected on that issue in our conversation at the end of her shift:

Ladina: It was just important for me to talk about it with her, why the baby calms down in my arms but not in theirs, so they don't start feeling that she's a bad mother or he's a bad father. Well, I thought the father was very present and he was very interested. I tried to make sure that everything suited both of them, or tried to involve him. I just explained that I've got a lot of experience and I've got the resources to soothe the baby. Because it's not my child, I don't have the motherly feelings she has, it doesn't stress me out. And because I can stay calm, that's why I'm more likely to calm the baby down, and, um - and that's how I tried to explain to them that they shouldn't feel bad. With breastfeeding, like she said, she was disappointed and she'd just imagined it differently (...)

Irena: Hmm, you said she'd certain ideas about how it ought to be and how it should work, or the ideal images she had were obviously not met, or not fulfilled yet.

Ladina: Well I did, I did ask her directly. She didn't have to put it into words herself. I did say, you thought it would be easier than that, breastfeeding I mean and she said, yes, absolutely.

Irena: Hmm

Ladina: She said she just couldn't understand that it wouldn't work ... and also that he was crying so distinctively. We tried to look at that - or I just kept telling them that. (C3/84-160)

The caring interventions in this situation were aimed at taking the stress away from the parents and calming the baby. 'Being with' and 'doing for' were the two caring processes and these were done in a quiet place as Fichardt *et al.* (1994) suggest is appropriate for such interventions. It was crucial in this state of anxiety to take over the affair to give the parents time to unwind. The next step is 'maintaining belief' by reflecting on the caring behaviour (Fichardt *et al.*, 1994) and comforting the parents in order to enhance their confidence. The nurse followed those steps and her interventions were successful. However, her explanation of why this had caused such stress for the parents was not consistent with what Carol told me in the final conversation:

Carol: On Sunday there was this situation with the baby. I was breastfeeding but I couldn't get him latched on properly and he cried so badly. Afterwards we had this talk with the nurse. She took time to talk with us and at that time I thought, he's [her partner] just sitting there so cool, you know? And she's making an effort and talking to us. I thought to myself, oh no, I'm worried already, when I get home with the baby and he cries like that, how's he [her partner] going to react to that? I got really worked up but I somehow tried to cover it up as it were. I then said to the nurse, we both were really worried and that we had difficulty with that situation.

Irena: Yes.

Carol: But actually, it was him who had difficulty with the situation, because I'd heard him crying like that on Saturday and I didn't find it bad at all. Then I got frightened again, um, how, how am I going to, you know when I come home and the baby cries like that and he can't cope with it, cos I don't want us to fight because of it, you know? I just had to cover it up. (C2/1058-1091)

Below the surface, there were relationship problems which were not disclosed at the time of hospitalisation. Shortly after discharge from the hospital, Carol separated from her partner and moved with the baby to her mother's. It appears that those unstated problems were upsetting her and causing distress. As shown in the research of Barclay *et al.* (1997), support from lay people, especially from the partner, is crucial in transition to motherhood, support which in this case was not forthcoming. Referring to Carol's care documentation and further observations, that incident was the first of its kind, others followed. Although evidence is given of intense emotional turmoil, such relationship issues were not touched on in any of the nurses' conversations with Carol. It is noteworthy that the woman desperately sustained an ideal of their partnership during hospitalisation as she frequently deferred to her partner and talked to the baby about his father.

Learning childcare

The degree of help and independence in childcare and breastfeeding was an issue throughout these women's time on the unit. I could observe nurses as they were discussing these subjects at handover, when considering what happened on the last shift and what was to be expected during their next shift. Involvement of the women is considered by the nurses as crucial when handover takes place at their bedside or when they introduce themselves at the beginning of their shift to discuss the care plan. There is also the fact that consistency in teaching childcare issues and 'enabling' women to take the responsibility upon themselves guides the nurses' actions.

The observed situations of Liana and Kirstin, both on their second day on the unit is an example of how they showed responsibility for the care of their child. At handover before late shift, issues of childcare, breastfeeding and women's well-being were raised. In Liana's case Simona, a young midwifery student was on late shift whereas Nurse Barbara, a mother of three grown up children was allocated to Kirstin. The women's and nurses' retrospective accounts present diversity:

Simona: Hmm, offered her my help, yes of course to help her and I gave her a bit – you know, I wanted to give her confidence, responsibility, so she could become independent with breastfeeding at the same time. So it's like offering my help if it doesn't work. (L5/103-108)

Liana: Yes, we just went together to change the nappy and I just let him [her partner] do it and I just told him what I already knew. They [the nurses] often came and asked if they could help us in any way but they had so much to do with all those women. (L2/554-561)

This situation is twofold. Simona indicates trust in the woman as she encourages her to take on the responsibility of breastfeeding. Liana on the other hand demonstrates learning by doing and at the same time is teaching her partner from what she has learned so far. Liana points to time constraints, which on the other hand might be the reason why Simona left them to themselves. Nevertheless, the woman confirms she felt taken care of and gives credit to the midwifery student.

The following quotes have been extracted from Kirstin's data set:

Barbara: I would say at the moment, the anxiety's the main thing. Yes, anxiety prevents her from doing anything else with her [the baby]. She bursts into tears just when she looks at her. She holds her [the baby] well in her arms, it's not that, I don't have the

impression she doesn't want to hold her or anything, not at all, but when she looked at her she got teary. But I think it's more, not just fear, it's also the joy, being overwhelmed, the baby. (...) It's simply, I think at the moment everything's just too much, everything all at once and so on. Feeding, extracting milk, the drip, pain, getting out of bed, and hmm, everything together and the baby and the new situation and the new environment. I think it's simply too much at the moment and when she's rested for a while – she also said she couldn't sleep at all last night. (K3/184-230)

Kirstin: The practical side, where you push the balance – can you change her please because I'm too lazy to get out of bed. For example in the middle of a night and on both sides, nurses were brilliant, absolutely brilliant. I couldn't think of one single complaint – against any of them, I mean not one. They were so – nice, all of them really nice, really sympathetic – you know. (...) You do it when you want, you have got your own routine, just we're here if you need us, that sort of thing. But I also, you know, take over if you're unable to do it yourself. So I think they just got it absolutely perfect, absolutely perfect, really (K2/1088-1143)

Clearly the interventions in the two situations follow the principle of responding on an individual level to the women's needs and show contrasting degrees of independence. Confidence building, attending to the woman and taking over childcare appeared to be the prominent caring actions. Referring to Swanson (1991; 1993) three caring processes, 'maintaining belief', 'being with' and 'doing for' feature. Reassuring the new mothers contributes greatly to how they succeed in childcare as Tarkka and Paunonen (1996b) reason. In the present study both women responded positively to those interventions but what also became evident in Liana's statement was constraint of time. Women are left unattended in their rooms at times, which can facilitate independence. Nurses are always available via the call-system. Availability of nurses will be an issue discussed later in this chapter.

To be able to learn and to carry out childcare depends very much on the women's well-being. The physical impact of a caesarean birth does not allow emphasis on childcare in the beginning since recovery from the surgery is the main concern. Hillan (1992) reports that physical recovery was a major issue after caesarean birth. A majority of women in her study found it difficult to take on the responsibility of childcare in the beginning. Consequently, those women remained reliant on the nurses as long as they felt drained. There was also a certain degree of reliance on nurses with breastfeeding, which will be explored in the next section.

Learning to breastfeed

Breastfeeding was obviously a new experience for all first-time mothers. Despite a professional background in health care (which applies to some women in this study), the opportunity to gain knowledge through discussions, antenatal teaching and reading, breastfeeding had to be learned. There were women, such as Flavia and Alicia and their babies, who learned more easily than others, like Giovanna and Kirstin. Yet, all ten women in the study group were eager to breastfeed. This corresponds with results from a study in Switzerland (Merten and Ackermann-Liebrich, 2004) indicating that 97 per cent of women initiated breastfeeding. However, figures taken from this respective hospital in the year 2000 demonstrate that at the time of discharge nearly 90 per cent of women were fully breastfeeding, which includes supplementation with water-based liquids, and approximately 33 per cent of women exclusively breastfed (Merten, 2002).

Moving beyond quantitative figures, it is necessary to add interview accounts of how nurses assist women in breastfeeding. Commenting on the ways women experience and respond to breastfeeding, one nurse reflects upon her observations:

Maja: Hmm, yes sometimes it goes so quickly, some women are fairly, hmm, and I got the impression she is very quick. She was able to do the other positions quickly and tried them out, yes she really wanted to try out and yes, that's what I noticed. (H3/16-21)

Nurse Maja acknowledges the different pace women have with learning to breastfeed. Inherent in her statement is the belief that there is a disposition where the dyad matches perfectly and learns easily. Another example shows how learning breastfeeding is experienced by Alicia:

Alicia: Well, breastfeeding honestly made a big impression on me, that it's at the heart of everything and hmm, they made it pretty clear that it works. (...) You can really learn it and the baby can learn it and hmm and this, I definitely picked up on that, more than I had expected. It's really just something with a couple of tricks to it, and, um, I feel it really helps you a lot and has taken me forward. (A2/256-270)

Breastfeeding as it appears in this account happened almost effortlessly and learning it contributed positively to her transition into motherhood. As this statement further suggests, the unit's philosophy of successful breastfeeding was evident. In our initial conversation, Alicia favoured feeding on demand and this was because of her mother's rather unpleasant experience with routinised feeding. She had expected to

obtain professional expertise, with which she eventually was satisfied. In the interviews women gave a variety of responses, but the main themes in this respect were almost always related to positive learning experiences. While it is difficult to generalise, it appears that most of the women in this hospital are enabled by nursing staff to learn how to breastfeed and take on this opportunity if they so wish. In the following statement, student nurse Larissa gives some insight in issues involved in teaching breastfeeding:

Larissa: Hmm, ... hmm, the first time I, um, when I went into her room in the morning and she said when I'd asked her if she hadn't had a drink for a long time, or when she had been fed the last time, then she told me she had been putting her to the breast at hourly intervals, so I felt, well there was an undertone of, you know, was that right thing to do, or what am I meant to do, or when I offered her glucose - it's just, mmh, well, that you could feel the insecurity she had - you know, 'What should I do now, what's good for my child, what's good for me, is this normal?' (A3/106-122)

With regard to the above, anxiety occurs in terms of responding to the baby's needs and it shows what women need to learn in respect of breastfeeding. This example also presents breastfeeding and teaching as a sensitive issue involving emotions and ideals. Additionally, already adopted routines may need correction, hence it asks for sensitive responses from nursing staff. In certain situations the ideal image of the breastfeeding woman, peaceful and wonderful, can considerably clash with what women eventually experience in their first encounter:

Kirstin: Hmm, I read all three books about breastfeeding but nobody said there is pain about, just about sore nipples, cracked nipples, what to do - if they bite, but nothing about this pain in the beginning, no. Actually, because I looked, I checked all three books and nothing. (K2/603-610)

Central to this view is that sore and cracked nipples are not connected with pain. Several women in this study experienced painful sucking but according to Mayes Midwifery Textbook, nipple damage is a result of incorrect latching and positioning (Sweet, 1997). More honestly, Laryea (1984) indicates that the first sucks can cause unpleasant sensations which women find difficult to cope with in the first days. She highly recommends discussing this issue with women before starting feeding as it influences the success of breastfeeding. During the first shift when I observed Kirstin and Nurse Barbara, breastfeeding became a major issue. The cracked and therefore very sore nipples added to the distress she was already experiencing after the caesarean birth. The woman became very emotional when it came to breastfeeding.

Nurse Barbara shared the pain issue with Kirstin and I touched upon that in the subsequent interview with her:

Irena: You said to her that you knew from your own experience with breastfeeding that it hurts. Would you say that to other women as well, you know that you can say this from your own experience?

Barbara: Yes, I say it now and again, yes, I say it now and again. And specifically in connection with breastfeeding I've often realised that women don't know it and it's not written anywhere either. It's not in the books, or at least not that I know about, that breastfeeding hurts at first. And it's sore for pretty much everyone, (...) Hmm, yes it's just something, from my own experience, I'd say it takes about ten days until you can breastfeed without thinking, that's uncomfortable or that's painful. (K3/338-384)

Sharing experience with other women but also with nurses is a mode of coping that women would adopt throughout their transition. Bondas-Salonen (1998b) states that sharing experiences and telling stories were important factors contributing positively to women's self-confidence. More often nurses would rather draw on their professional knowledge and experiences but women sometimes would ask the nurses if they were a mother themselves. Barbara's response was initiated by both, her professional and her personal experiences as she explained in our conversation. However, while Kirstin perceptibly acknowledged Barbara's explanation, she was too overwhelmed to take the message any further.

There were also a few indications that something was not introduced in the correct manner to advance breastfeeding:

Diana: Hmm ... yes well, in terms of breastfeeding, I just thought, yes, somehow I felt the lack of a proper introduction. Well it all started in the labour room when they gave her to me for the first time and simply said, okay now you can breastfeed her – yes. So I just left her on my breast and the midwife rushed out and I let her suck on one side. After half an hour when the midwife came back and she was still sucking on the same side she said oh, well, she should come off, you can change her to the other side. She was on the other side for another half hour, well, she was probably just playful licking and of course I didn't know. I just let her, you know, and the result was, the next time my nipples really hurt because she stayed on for far too long. And then later [on the postnatal unit] I did ask a nurse how long would be good to let her suck and she said, well about ten minutes. Okay then I left her for ten minutes because at that time – I didn't realise if she was actually sucking or just licking and nestling (...)

Irena: It sounds to me a bit like on the one hand, you got contradictory information and also, like you said, that you didn't get a proper introduction.

Diana: Yes – well, I just felt that they just left you to get on with the breastfeeding. Yes, personally I'd have needed – hmm, I would have needed a kind of introduction. Of course I knew certain things from the antenatal classes, such as she should not only take the nipple and that there're different positions, luckily I already knew that much. (D2/1387-1493)

Following the recommendations of the WHO/UNICEF (1991) 'Baby-friendly Hospital Initiative' (BFHI), health care professionals were to help women to initiate breastfeeding within a half-hour of birth. Putting newborn babies to the breast as soon as possible facilitates successful breastfeeding and mother-infant relationships. In this setting, the initial feed takes place in the labour room and therefore the midwives are responsible for the introduction. With the additional evidence given by some other women in the study who also suffered from sore and cracked nipples, it can be concluded that first and subsequent latches were not always correctly carried out. The structure of care organisation and its influence on care, as previously mentioned, features again. Midwives from the labour unit although they initiate breastfeeding are not in the position to continue teaching breastfeeding. Although stated in the documentation and reported at handover that the initiation of breastfeeding had taken place the nurses take on a job unsure of the quality of the first latch. Information given by midwives to nurses is neither complete nor is it always fully understood and therefore interventions might not always be appropriately followed up. Women mentioned their previous experiences considering the way they were taught, and such situations can give rise to conflict between midwives and nurses. However, such issues were not always discussed overtly between the two professional groups as I observed during my fieldwork.

In my first observation of Diana, midwifery student Marika was allocated to her. At that time, the woman was still bed bound to the extent that she needed help with finding a comfortable position to breastfeed and with attaching the baby:

Marika: Her nipples are quite sore, yes this is definitely so with the right breast, and now she has a break from breastfeeding for 24 hours and she extracts the milk. (...) And yes, the left side has started to become sore as well, it's cracked too but she still puts the baby on that side, but she might have to have a break on that side too. We offered her that, but she said she would miss something if she couldn't feed at all. (D3/12-27)

The above statement gives evidence that breastfeeding is part of the nurturing role of mothers. An interval may indicate a feeling of failure or loss of closeness and in such situations alternative ways of nurturing the baby are to be encouraged. Accordingly, success with breastfeeding enhances confidence, which becomes essential in this transition process. On the other hand women recognise their dependency as they

need support from the nurses. While the baby is determining their schedule, they also depend for a certain time on the nurses' expertise:

Giovanna: You're incredibly dependent on them. For example with breastfeeding when you're not capable of doing it on your own and you need help as the two of us [mother and baby] were, you're really depending on them, that they have time and that they come and you can't wait like you would with a broken leg and hmm, you need them (...) you can't wait half an hour because she's crying and I can't let her cry for half an hour. In the beginning I just couldn't do it myself and it just wasn't working, whatever I tried, and when I tried it on my own she only got nervous and crazy and I got nervous and she wouldn't have latched on properly anyway. (G2/517-540)

The urgency of help needed brings out dependency on staff and this was felt strongly by this woman. Giovanna's statement gives emphasis to the argument that women in this setting become patients. Again the structure of the institution and the procedure of care denote patient-like behaviour.

Finding rest

Throughout their stay at the hospital, time and space were issues raised frequently by women, and also by nurses. These are important factors to allow for rest and recovery from the physical strains of pregnancy and birth. Nevertheless during the time on the postnatal unit many new tasks have to be learned. Frequently occurring caring tasks, disruption from staff and women sharing the same room result in interrupted sleep at night and finding time for rest during the days is very difficult. The phenomenon of feeling tired after birth is discussed in the literature chapters. Despite women's expectations of being tired after birth the magnitude of it is something new for all of them. Barclay *et al.* (1997) refer to feeling drained which affects physical and emotional well-being. Despite feeling tired women in this study showed a desire to be together with their baby as much as possible as it seemed essential to discovering the nature of the baby and establishing a relationship with her or him.

Being together with the baby

Women in this study revealed their informed understanding of the rooming-in policy of the hospital in our initial conversation. This policy complies with Step Seven of the BFHI (WHO/UNICEF, 1991), which is, “practice rooming-in – that is, allow mothers and infants to remain together 24 hours a day”. The unit’s guideline about rooming-in complies with the above but despite this principle, I could hear that nurses offer to take care of the babies at night if the women needed that and wished so. Additionally some women in this study decided to have one or two quiet nights to allow themselves a sound sleep:

Irena: As far as I can tell you were relatively active.

Liana: Well, one day I realised that I’d done an awful lot the day before, that I’d taken on too much in my condition, you know with driving about everywhere, changing nappies and so on, so that day I left some of the care up to them again, some of it, and then when I felt better again, I’d do it myself again. For the first two nights and this was on purpose, when she was sleeping and after I’d fed her, I gave her to the nursery because I just thought if I can sleep for these two nights, I would feel and cope better.

Irena: And that clearly worked out for you.

Liana: Yes and because of that I’ve had her with me ever since. (L2/225-249)

Adherence to the guidelines appeared secondary to the well-being of women and babies. Although 24-hour rooming-in is considered essential to ensure successful breastfeeding and to promote mother-baby bonding, the nursing staff on the postnatal unit give preference to the women’s needs and value their well-being more highly than adhering to the policy. This leads to the conclusion that women and nurses prefer a less rigorous practice than the guidelines recommend. Similar results were discovered in an evaluation study of 28 Baby-Friendly Hospitals in Switzerland (Merten and Ackermann-Liebrich, 2004), which distinguished between two levels of rooming-in practice: continuous and partial rooming-in practice. Continuous rooming-in is understood as staying together as a dyad day and night. Partial rooming-in is either where mother and baby stay together day and night with the exception of some nights, or where rooming-in is practised only during daytime and never at night.

In Merten and Ackermann-Liebrich’s study (2004) continuous rooming-in was practised for an average of 45 per cent of the dyads in all of the investigated hospitals whereas the setting where this study took place scored at almost 60 per cent (Merten,

2002). These average figures mirror what I could observe with the ten dyads in this study and such a result does not resemble BFHI's over-simplified and highly functional recommendations of practising rooming-in. Relationships between mother and baby are tacitly assumed to express only a single set of needs, those of the baby, which unite the two human beings. However, by recognising only the baby's needs, this view of the dyad ignores evidence of motherly needs and makes little reference to the ambiguity in such situations. In particular, the BFHI's recommendations fail to take on board the standard view of women in which the critical importance of rest and sleep may influence their future relationship. This becomes particularly clear in Kirstin's account. She was one of the women who requested that her baby slept in the nursery for some nights as she was exhausted from labour and the subsequent caesarean birth:

Kirstin: At the end it just finished me off. I was completely, you know, I didn't expect that to be so completely finished at the end of it, because it was, it was just, it was too long and – the caesarean is a big operation (...) I just felt like death afterwards, just absolutely like death for days, two, three days, I could hardly move, because I just felt so terrible and that's, I didn't expect it to go so bad. (K2/731-748)

The above statement is in tune with what was said by the two women in this study who also had caesarean births. The physical impact of caesarean birth hindered their full engagement in childcare at the beginning. This corresponds with Hillan's findings (1992) as 44 per cent of the women in the study group reported such difficulties on the third or fourth day after a caesarean birth. They lacked rest and sleep and felt physically drained. Women's well-being greatly influenced their ability to care properly for themselves and their babies, hence they depended on the nurses' or lay support. However, McQueen and Mander (2003) question whether greater professional and practical support would prevent tiredness. Despite this argument they believe that adequate and appropriate information about how to cope with the demands that follow childbirth would help mothers to make a better transition to motherhood.

Nurse Esther was caring for Kirstin on the fourth day of hospitalisation. The woman was emotionally distressed and predominantly absorbed in what was going on with her. Additionally, I observed that worries about the baby and difficulties with

breastfeeding were dominating the caring situation. When I asked Nurse Esther how she perceived Kirstin's response to her baby she summed it up as follows:

Esther: Well I believe she's still very preoccupied with what's been happening with her. Yes, sometimes I have the impression that she's only got relatively little capacity left for her baby. (K4/448-455)

What is expressed clearly in this statement is that the recent experience absorbs energy, and hence causes exhaustion. Sethi (1995) notes of the women in her study that learning to care for the baby could not have much priority since they were constantly challenged by adapting to their new self. A redefinition of their being and their social relations would have been inherent in this transition process.

The above statements from Kirstin's data set also suggest that expectations and the subsequent experience in labour influence emotional well-being. As mentioned earlier, being in control during labour was one factor responsible for feeling satisfied, influencing how women coped afterwards (Green *et al.*, 1990; 1998). As Kirstin was upset about the birth process, uncertain and challenged with constantly learning new tasks, she could not relax and regain energy. Hence, her feelings of physical and emotional exhaustion were growing rather than diminishing. Additionally, the numerous interferences on a unit contribute to disruption and disturbance of women's opportunity to rest and recuperate.

Unit's routine

Finding time and space to rest is further determined by the unit's routine. Hanna was talking about the perceived effect of the routine in a general sense:

Hanna: Well, I had some quiet times, hmm, times when I wasn't disturbed by whoever, and things. So in that sense I had moments when it was silent but not in the sense that there was nothing or moments just to relax, there was just always something. (H2/642-649)

Britta gives a more detailed account of how she perceived the routine on the unit:

Britta: Well, I got the impression there was always something going on and time for me, well, there was sometimes a half-hour or an hour but I wouldn't say much more. And you know, you get visitors and yes, there was always something going on. And in the mornings, I'd the feeling, oh, I have to go for breakfast now, otherwise there'll be nothing left for me. And of course if she came at 7.30, it really became almost stressful, that's at least how it seemed to me. Then you've this visit from the paediatrician and I

should go along with her, or you'd like to go along too, then nappy changing, then breastfeeding – well, for me it was almost really stressful, the whole day.

Irena: Yes well, also because of the routines that are organised.

Britta: Yes, I'm aware that they need some kind of routine but that's just how I perceived it. (B2/484-510)

These accounts suggest that women in this study made an attempt to follow the unit's routine, which restricted their time to recover. Again, there was a tendency to adhere to a patient's role rather than questioning the routine. Tarkka and Paunonen (1996b:1204) mention that women in their study described their time on the unit as "a quiet and peaceful experience". Conversely, those women support the view of Britta as they also perceived disruption of their own time from the daily routine on the unit.

On the other hand, nurses practised a particular organisational workflow, dictated by the hospital's day-to-day process in which they were relatively powerless. Nurse Leah reflected on the time constraints, which applied to Britta's situation:

Leah: Yes, I felt that I didn't have much time for her, if I'd had more time she probably would have come with more questions – hmm – to me, yes, but beside that ... it's difficult to say ... yes, I think it was okay because she definitely would have come if she'd needed something. (B4/56-65)

The above statement indicates interplay between nurses' availability and women's likelihood to ask for support. Low availability affects women's behaviour since they reluctantly withhold their demands, hence increasing distress and influencing evaluation of care provision. Diana accounts for that in the following statement:

Diana: Well, I found it very tough – a hard time – yes it was a hard time that week I was there and – exactly this respite and time for me, like you said, that was something I didn't have. It was always very unsettled, there was always something going on. Of course, during visiting times – hmm, but also beside that there were the nurses who came and went and hmm – and they needed to do something either with me or another woman, or a new patient came, so, yes, I never really managed to get a proper rest at all (...). They were, yes if I asked them for something they really tried hard to help you and – I think they tried to do their best but it was simply – they were so stressed. They rushed around all the time, there were so many patients there. (D2/48-106)

What becomes apparent from the above is how workflow and staff availability influenced women's behaviour. The time at the hospital and care they receive are intended to be beneficial for women. Whereas the rooming-in practice is aimed at supporting mother-baby bonding and learning to care for the baby it causes a lot of traffic in the women's rooms. According to Cuttini *et al.* (1995) rooming-in practice

has its negative aspects as women perceive the demands of childcare as limiting opportunities to rest. Moreover rooming-in does not lessen the nurses' workload as the amount needing to be taught to new mothers or parents increases greatly.

Whereas 'being with' women in distressed situations should be of utmost importance the busyness on the unit affects such 'being with'. Moreover it influences the women's access to care, which eventually can also harmfully affect them as they miss out on important issues. This finding is supported by Bondas-Salonen (1998b) as women in her study tended to understand that problem. Instead of criticising nurses or increasing their demands on them, they excused them. However, while participating women displayed a reluctance to overtly express their displeasure about limited accessibility to care, they were able to maintain a sense of freedom because they had the potential to exert some self-care over their situation.

The following account from Kirstin demonstrates the strain she felt while she was on the postnatal unit:

Kirstin: That was the only problem with hospital, no sleep, no rest at all and you need rest – and I think it makes it very stressful, being in hospital – when you can't sleep. That's the worst thing that can happen, really – but there is nothing you can do, nothing unless you go private. (K2/281-289)

It is noteworthy that during most of my observations the unit was fully occupied and therefore very busy. Such a high level of workload eventually results in constant busyness, not allowing staff the time to fully attend to women and babies and this reflects on their day-to-day practice. Nevertheless busyness is not the only determining factor for finding time to rest and recuperate since other women and the flow of visitors on the unit influences the atmosphere considerably.

Visitors and other women

In this particular hospital visitors are allowed on the unit during the day with few restrictions. In this study, women generally controlled the stream of their own visitors by informing friends and relatives how they wished to be visited. In certain cases, nurses would advocate women's need for a quiet time in agreement with the women by asking visitors to stay only for a limited length of time. However, visitors

for other women in the same room could not be controlled easily and often they were perceived as intrusive by the participating women:

Eleonora: But during the day, her [one of the other women] first son was here from early morning till late and she got a lot of phone calls. The other woman had to use the milk extractor frequently and I just felt it was like being at a market place. I realised I was reaching my limits and also – because my baby was coming so frequently. It was like there was something going on all the time, all the time. If there wasn't anything with him, then it was time for a check, so there was something going on all the time. I didn't see an end to it, in this – this carrying on. (...) I couldn't bear it at that time and yes of course, the heat in this room, just everything together. (E2/815-833)

What Eleonora says makes obvious that it was not only the visitors who were interfering with her own space, it was also the other women in her room, whom she perceived as disturbing. In a three-bedded room, there is no space to totally withdraw. At times of full occupancy the possibility of transferring women to another room is impossible or at least very restricted.

During my observation, I saw the Nurse Manager had made attempts to allocate rooms for women in a sensible way. She explained that women from the same or similar ethnic background would be allocated to the same room whenever possible. This, however, was never guaranteed nor always desirable. Such segregation might seem discriminatory but it also can help women to engage with each other. More often than not it was appreciated by women, as the Nurse Manager recounted. This especially applied to women who did not have full command of the language and appreciated support and help with translation from peers.

What also became clear from previous accounts was that women were exposed to what was going on in their rooms and the interference could be rather disconcerting. However, Flavia, for example, was able to create space for herself:

Flavia: Well especially in the evenings when the visitors were gone and hmm, we [she and her partner] usually went out to the garden or something ... but beside that (...) rest during the visiting times, no, it wasn't quiet at all at evenings. Once we went out for a meal. (...) I wasn't worried at all if she cried or not. (F2/379-400)

Yes, I was so busy with my baby – yes and somehow, maybe I didn't want to hear what was going on with her [the neighbouring woman]. (F2/651-654)

The excerpt shows Flavia's ability to withdraw into her private world which gave her the opportunity to find rest and peace, and as a result she was able to concentrate on her baby. As discussed earlier in this chapter, such time to create a niche is pivotal where woman and baby can be together privately and quietly as this contributes

positively to maternal-infant bonding (Klaus and Kennell, 1982). However, this featured rather scarcely in the busy environment of the unit. Liana reflected on that issue in our final conversation:

Liana: Well anyway, what's definitely lacking is the intimacy, of course, that you have in your own home, because there are always people there. And you can't just, you know, when you would like to natter about something, that you might not want to do in front of other people. You had to, yes once we went outside and that worked, but in your room ... (...) But otherwise we just took our personal space – with closeness, I mean. (L2/504-522)

Liana: Hmm, yes but well, to have your own space you know, I think when you're at home and you have to cook and all that but there you're looked after and you have time for the first and most important things. Yes, this is, I could appreciate that.

Irena: Having that space.

Liana: You got pretty spoiled and just have time for yourself, the baby and for other things. (L2/1402-1415)

Liana compares the time at the hospital with the first days at home. Her evaluation is based on the additional housework she now has to attend to. From that perspective all the time at the hospital was just for her, her partner and her baby and she was able to actively create her private sphere.

Several issues feature in this topic bringing to the fore the disharmonious effect on the journey to motherhood during this liminal phase. While the postnatal setting provides a space to be, to rest and to learn, women experience many kinds of interferences, which are counterproductive to growing smoothly into their new self and new role. Additionally, the balancing act between dependency and independency with professionals is daunting at a point when women need their energy to cope with the changes in their life. However, when women become aware of their impending discharge their need to be in control of the caring tasks emerges. In the end, their journeys take a route between routine, expectations, and individual pace of adaptation, and between doing and becoming confident.

Anticipating Life with a Baby

A central goal in postnatal care is to prepare women for the time at home. All caring activities are aiming at enhancing women's capacity to fully engage with the new role as a mother. Acquiring caring competencies is essential to performing the role as

a mother, however women realise more and more the physical impact of childbirth as tiredness comes to the foreground. Transition to motherhood depends also on the interaction with the baby, the social environment and the perception of the self. The postnatal unit as a liminal space provides some shelter for the time being and this can give a sense of protection where women cope with the new tasks and life with a baby. However, anticipating discharge can provoke a feeling of aloneness and Barclay *et al.* (1997) state, this in cases can well be positive as women are able to find their own way. The downside of it is that aloneness can be distressing as the many new tasks and coping with them might not be feasible. Women in this study had made arrangements for lay help during the first days at home but no professional support was arranged. This subject will be discussed more fully in Chapter Six.

Doing the care

Caring for the baby and oneself, and learning how to do it takes time. Some women in the study realised that there was not much time for adaptation as they were thrown into this state of being a mother and taking care of their babies. Diana expressed the challenges of coping with the care:

Diana: Hmm yes and I think there is no real training for it. All of a sudden it's here and you've to find your way of dealing with it and it's sometimes not that easy.

Irena: Hmm, you just have to know how to do it.

Diana: Yes, right, you just have to know how to do it. (D2/1757-1766)

This statement suggests that taking on the responsibility of caring for her baby seemed difficult for Diana. Her physical condition restricted the opportunities to experiment with childcare in the first days post-birth, something Flavia was keen on. Although Flavia had difficult moments, as she found the role of a mother suddenly imposed on her, she engaged in childcare whenever possible:

Flavia: In hospital, they know exactly how to do things but at home nobody is watching you all the time – and that's just – yes ... or just having the time to try things out, yes – or you know in the beginning we did a lot of things together, my partner and me.

Irena: To find out together how it works? (...)

Flavia: Yes exactly or you know they do everything so quick and you're doing it so slowly, yes, (...)

Flavia: They've really taken a lot of time and given me the opportunity to do it myself. It's not that they've taken over or anything. (F2/270-315)

Role play appears in Flavia's statement and as Rubin (1984) states it is an important element in development and growth into motherhood. In order to be able to experiment with the new role, women need their own space as they can feel confined within the hospital setting to some degree, as is indicated above. In this context support can be perceived as either helpful or unhelpful and the line between the two attributes can be very fine (Podkolinski, 1998). How women experience support depends on their needs, how they perceive their needs are met but also on the motivation of the nurses who support them.

Nurse Jennifer was assigned to Flavia for four consecutive early shifts. After two days she reflected on the woman's well-being, hence her support needs and her perception of Flavia's readiness to take on childcare.

Jennifer: I didn't expect that she would like to do the baby bath this morning. I first thought, maybe do more on nappy changing. But, you know, that was because of my thoughts yesterday when I left the unit and from what I heard this morning from the night nurse. I just didn't think she'd want to. But otherwise, as a person, I'd say she'll very quickly be able to do as much as possible by herself with her baby. Well and really, she suddenly felt so much better this morning and of course, we often have to react to things like that, so we can just say, yes, alright, let's do it that way. At the end of the day, it doesn't matter really. (F3/479-498)

A key concept of this interview extract is orientation to the individual. The rapid change of women's physical condition requires constant adjustment in care provision. Individualised care considers individual needs resulting in success with self-care and childcare and it is linked with the quality of care new mothers receive (Tarkka and Paunonen, 1996b). Doing the care is not only about managing the practicalities of self-care and childcare. Confirmation is also important as can be seen in Kirstin's perception of Nurse Esther's response to her in the following statement:

Kirstin: Somehow, yes in all of them, they, the way they were all were very supportive, you know, even when you're changing the nappies, they got very supportive, the way they said, yeah, that's great, well done, good and I could hear them, all of them saying, you know, but it was, it was really well done I thought. I did recognise that, but I thought, you know, just giving you so much praise as well. Yeah, you change, yeah you got time for changing, is it really your first time, just look at things like that. It makes, you know, they're probably thinking, oh God, get on with it, but it doesn't show, you know, they're always really, really positive about it. And that makes you feel very positive as well and that was quite, just little things like taking her clothes off, it is quite difficult the first time you do it.

Irena: I remember the situation (...)

Kirstin: And she said, is it really your first time? You know, you do it really slowly, badly. But they were always so positive and I thought that was a real good thing as well as that lets you feel or when you express milk and you got like, you know ten grams or what ever is in there, you know really little and they go like, well done, yeah, that's brilliant. (K2/1221-1266)

As an observer of this one particular episode, I was interested to hear from Esther how she perceived Kirstin in the situation:

Irena: What was your motivation for telling her that?

Esther: I want to confirm to her that she's doing it well and also that she, that she gets, feels good as a mother. And she did fine; there is no question about it.

Irena: Hmm, yes.

Esther: Well of course she still didn't know what the best way to do it is, but that doesn't matter. She was very careful and her baby wept only a little bit and that's why I thought she did really well.

Irena: So in terms of handling, how she acts with her child, you'd say, it's absolutely...

Esther: That's something that comes quickly, I'd say, and it was very well done for the first time. (K4/414-444)

One of the basic caring processes, which is 'maintaining belief' (Swanson, 1991, 1993) features in this excerpt. The nurse's intention to sustain faith in the woman's capacity is crucial to support the transition process. Unlike other women in this study Kirstin specified what was important in contributing positively to her self-esteem.

Most women supported this statement in a more general sense and Flavia expressed satisfaction with the kind of support she received by saying: "I didn't expect to get that much from the nurses" (F2/1404-1406). Women recognise and appreciate emotional aspects of support as Podkolinski (1998) reports. Commending and reassuring, reinforcing confidence and responding to questions and concerns were specific caring actions to support women on an emotional level. This could be observed on many occasions. In reference to Tarkka and Paunonen's study (1996b) affirmative and affective caring was less likely to be received than practical care. Since the current study does not quantify results such a conclusion cannot be drawn from the data. However, 'enabling' women to do the care was important to all participants as they perceived training for the time at home as crucial.

Gaining and losing confidence

The importance of learning childcare and becoming confident in those issues, in order to feel prepared for afterwards, featured prominently in the initial conversations. Women's expectations will be explored more closely in the next chapter. The following statement taken from Diana's data set shows how this developed postnatally for her:

Diana: Hmm and with childcare. Well, in the first few days I couldn't do anything at all. They taught him [her partner] how to change nappies and to bath her and – later, I can't remember exactly, it was probably on my fourth day, I went with her just to watch and from Thursday onwards I could do it myself and then I said I would like to do the bath on Friday together with a nurse. Yes, we did it together and it was good. (...) Well – I, I couldn't, just physically, it just wasn't possible, you know? I definitely missed that, yes, I mean, it was Thursday when I saw her naked for the first time. (D2/72-180)

Diana's account is an illustration of the time issue in taking on the responsibility of care and how her physical condition influenced this. Although her partner's presence allowed for an acceptable involvement some regret resonates from Diana as she missed out on caring for her baby from the very beginning. It appears that the process of building up confidence depends also on how women have been involved in getting to know the baby.

The next statement sheds light on caring issues in general. Learning to care is a constant and gradual process and confidence in that respect develops coincidentally.

Hanna: Yes it was actually quite good with that as well, well for me, for my own care or to say with breastfeeding and that whole issue, I did feel, well, confident. Well I realised I have these little problems with breastfeeding but I also knew how to tackle them. (...) The same with childcare, well in the beginning, they instructed us a bit, and soon we could do it ourselves. We'd mainly do it ourselves and because of that, yes when you do it yourselves, you did feel really confident and also with bathing. They showed us on Sunday how to do it, what you need to look out for and in this sense, with childcare, well – yes I felt fairly confident. (...) Yes, in terms of childcare I felt pretty confident and they were really good at teaching us. (H2/737-791)

Postnatally, there was considerable evidence from participating women that they felt competent in childcare and breastfeeding as they moved on in their journeys. In retrospect, and based on several statements in the transcripts, the level of satisfaction with how they were taught childcare can be estimated as high. The focus on childcare is mirrored in multiple entries in the care plan and it was brought to discussion at every handover as I observed. Self-care was referenced as well but it had much less priority as women reflected in our final conversation. Nevertheless the nurses aimed

to ensure that women got the time and support needed to become confident and to take on the responsibility of caring issues. Commenting on Britta's self-assurance, a fourth year student nurse explains:

Muriel: She's become more confident with the baby and also with nappies, she can really apply it now and practise, but I don't know about the bath. (...) Also with breastfeeding, she really has become assured, you know in the beginning she really had a hard time with putting her to the breast and holding her close enough, but now this is really, this is good. She really does a good job and has gained a great deal of confidence. (B5/588-605)

As a result of continuous allocation, nurses were able to assess women's confidence more adequately. Larissa, another student nurse was in charge of Liana during three early shifts. Her observation over time enabled her to conclude that the woman would do well at home. One indication was Liana's independence. This on the other hand would not necessarily prove right in every respect, as many women can be left to themselves without gaining confidence:

Larissa: She's taken over most things and is mostly independent. (L3/585-586)

Interestingly this holds true in Liana's case. Sensitively aware of her own abilities she could decide what she needed and ask for that despite perceived restrictions imposed by the unit's routine:

Liana: At the end of the day, you've just got to be able to decide for yourself, I think. (L2/753-756)

Liana further reasoned that confidence would be something one either has or has not but the prospect of going home could well shatter one's confidence. Some other women in this study started openly to question their confidence in their caring abilities in anticipation of going home. Barclay *et al.* (1997) found that women in their study frequently associated the prospect of going home with the responsibility of taking on their new role. Minor incidents could provoke uncertainty and only moderate and sensible advice helped women to trust they would cope well. Whereas life with the baby had become part of women's reality, life at home had an air of unreality. The following quote from Alicia's final conversation represents this:

Alicia: Yes ... and for myself, on the fourth day I felt a bit, hmm, I didn't feel confident about whether, if I'd feel alright and because she said I could call any time on Saturday – hmm, this gave me just the confidence I needed. Yes, that was enough – and then everything went well. (A2/290-297)

Similarly, Flavia explains how she felt shortly before discharge:

Flavia: Well, confident, well, all of a sudden, you know somehow I was still so weak and tired. And all of a sudden I had this feeling, oh help, I can't cope as well as I thought I could. But now at home it's not a problem with bathing or things like that but at first, yes, hmm. I was really glad that they'd helped me so much, hmm yes. (F2/222-232)

It is a critical time when women go home. The only experience they can draw on is what they have learned during the time in hospital. Again, the woman's physical state plays a part if she feels exhausted. Additionally, women suddenly face being on their own. This was mentioned by most of the women in this study, even though in all cases but one, they could count on the support of their partners who remained at home for some time after discharge. However, women made no mention of that fact in our conversations, which could well indicate that they saw themselves as the primary caregivers. This could be an effect of a woman-centred care approach.

Nurturing the baby was of great concern to women in this study and the ability to breastfeed independently and successfully contributed to how confident they felt at the threshold to going home. All women but one in this study exclusively breastfed their babies at the time of discharge. However, some women were extremely challenged as breastfeeding did not work well. This is demonstrated in the following extracts from Giovanna's and Hanna's data sets:

Giovanna: It was an advantage that she [the baby] had to stay one more day because that day allowed me to become more confident. (...) Hmmm, I couldn't wait to go home and I wanted to go home but just, you know this feeling of certainty. (...) Because I still didn't feel that confident on Monday, you know putting her to the breast and so on, and not on Tuesday either, but it was better because by then I had managed it two or three times, yes I could say I had managed to put her to the breast entirely on my own. (G2/1173-1214)

Hanna: Yes it was just, hmmm, hmmm, yes, a very hectic day. It started well and then, all of a sudden I was told and this was before I had had my breakfast or anything else, I could go and see the obstetrician now for the examination. I would have liked to have had shower first or to have known about it five minutes before I had to go. So it was a real rush but yes, I could cope with that, this didn't matter much but the next thing was with the paediatrician. I was about ready to breastfeed and because the baby was really, really hungry and we were just about to start, but then he had to go and see the paediatrician. Okay, he didn't cry that much, but it caused such a delay and it was really hectic, this to and fro and the engorgement, which was really bad then, and he couldn't drink properly and he needed a lot of time. This to and fro and trying with extracting milk and everything and my breasts were, um, getting more swollen, but more like congested, and then, yes and then I thought, I just need a bit of time, to relax and to rest and so on and then everything will be fine. Just don't make a fuss and I just said, I'll take my time and wait till I feel better and then I'll go home, you know? Of course yes, and then, it dragged on until late that day. (H2/358-402)

Both women state that time was an important factor as it allowed them to become more experienced with breastfeeding. It seems that every latch takes them closer to home. However, a certain level of conviction that they would cope well with breastfeeding at home seemed to be a key element in developing their confidence.

What emerges in the second statement is the way a hospital routine can cause distress. Inclusive in the process of discharge was the medical examination of women and babies. In Hanna's case these examinations were inconsiderate of her individual situation. They both influenced and interfered with her course of actions and made her feel uncomfortable as she obediently complied with the imposed schedule. As a result breastfeeding became more difficult for mother and baby.

This example is one of a few I observed, which demonstrated the differing views of the medical and nursing personnel. Whereas nursing staff consider women's and babies' routine to a great extent, medical staff organise their schedule to suit themselves and drop in at their will. Whether this is due to work organisation or disregard for individuals' needs is debatable. In the conversation with student nurse Laura I inquired as to what extent she could influence the course of events on the day of Hanna's discharge:

Laura: This morning with the obstetrician it was just like that, when he came, she'd just finished feeding – and it was just the time was really...he didn't have any other women, but he had enough to do besides that, and he couldn't go to any of the others because they were all feeding. She herself said, yeah, it doesn't matter, because she had just finished feeding and had put him [the baby] down anyway. So because of that, I left the decision up to her. She could have said no but she didn't. And with the paediatrician, that was totally inconvenient because she [the paediatrician] was in such a rush to go to the NICU and had no time and in this situation, - yes, I just didn't realise, you know that she was just about to breastfeed. (H4/152-176)

Although the two professional groups were working alongside each other, it becomes obvious here that their attitude towards work lacks a common mission. It could be argued that medical staff impose power on women as they decide their routine, irrespective of the new mother's situations. Such an example not only raises questions in terms of differing attitudes towards the individual, it also gives rise to conflicts between professional groups. From the perspective of the nurses' role of advocate, the potential for supporting women in decision-making was not completed. Leaving women unsupported in such situations raises the question of the power balance between women-nurse-doctor.

Women in this study realise that the event of discharge brings changes. This did not only occur as a loss of confidence, as we see in Eleonora's statement:

Eleonora: It was strange, I didn't feel as strong and determined any more (...) well I think it was the tension and – well I don't know really, I can't really explain it. It was just like feeling lost and – yes – the next day, everything was different again. (...) You must take this little thing with you. All of a sudden it dawned on me, you know two of us came into hospital and now three of us are going home, that was strange. (E2/1392-1435)

The aspect of now being a family is brought out by Eleonora. This statement denotes the transition to parenthood, hence it shows the magnitude of the change in the social structure and how it can influence women's confidence.

Statements in the above section show the fragility of women's confidence and how it alters over time in hospital. It is remarkable that women become uncertain of their abilities at the threshold of going home. They feel the demands of the responsibility, and many felt they were about to be left on their own.

Feeling alone

The timing of discharge is coincidental with the timing of feeling blue for those women who were discharged on their fourth, fifth or sixth day. To realise the magnitude of motherhood in an emotionally intense state can be daunting. This leads to moments of self-doubt, which are not beneficial for a positive experience of moving home. In the following excerpt Britta reflects what she experienced shortly before going home:

Britta: It was fairly good, you're just still in this weepy mood, yes I still had that. (...) Yes, I just, I felt like I could have cried at any point. Okay, not all the time, you know, but - more from joy because she's here now and things – but that's stopped now.

Irena: Was that during the first few days at home?

Britta: Yeah, it actually started at the hospital and then, then on Friday again but after that no, not really any longer. I just can't cope with a lot, or rather I wasn't able to cope with too much, I suddenly did burst out in tears. (...) [Leaving hospital] was like saying good-bye, or at least that's how I felt, that now, yeah, something's over or finished – I feel like it was more because of the people there, because I wouldn't see them again (...) yes, you don't really have anyone around you any more ... really, nobody. Of course you could always phone people ... (B2/687-764)

What is brought out here is the "condition of emotional lability characterised by crying" (Oakley, 1980:114), which is known as the postnatal blues. This weepiness is

a temporary problem as women generally feel alright after this usually short episode. At this stage women again realise the responsibility they have in their new role, and again they feel unready for this next step, which provokes anxiety. Joy of having a baby similarly can cause crying episodes. The coincidence of feeling blue and discharge might even increase the level of anxiety temporarily as women understand they will not have the same support they have had thus far. Liana, who was fairly confident throughout the days post-birth suddenly felt worried:

Liana: When I was in hospital I was still worrying a bit, okay, now you're going home and there you can't press the buzzer and somebody'll come, yes, how's that going to work out? But then I got home and I felt totally fine from the very first moment. (L2/103-110)

As a consequence of hospital care reliance on staff becomes obvious as the woman is due to discharge. As first-time mothers are lacking sound experience with caring tasks the time at home is yet an unknown. When I was talking with the women before birth, they all were aware of this emotional state of feeling blue and they expected it could overcome them. At the point of going home some of the participating women experienced an emotional vacuum. The following explanation indicates the magnitude of this postnatal stage as it was perceived by Flavia:

Flavia: Hmm you know it's become more and more stable now, but there I just felt, because I felt so kind of helpless, almost, and sometimes I felt, well I found myself put into this 'being a mother' and that was when everything seemed so difficult to me. And ... hmm, yes, you know, I'm kind of, how can I put this – I was just pretty genuine, yes when I felt I need to cry I did. (F2/779-793)

Nurse Jennifer describes how she perceived Flavia shortly before discharge:

Jennifer: Well, when she feels rested she's much more able to realise that she's actually doing it right. When she feels drained and hasn't slept much and feels like she's rested too little, too quickly, then she also immediately starts feeling, oh, am I up to everything that's coming my way. Because as soon as the child becomes a bit restless, you kind of feel her restlessness too, which in turn starts growing more. But when she feels well, she takes her baby out of the cot, takes her into her bed and says, see, now you like it here, don't you? (F4/492-507)

As a result Jennifer adapted the pace in the day-to-day routine and times of rest were discussed. Moreover, the nurse raised the subject of postnatal emotionality as she became aware that maintaining confidence and ideas about how to cope with it at home were crucial. This and other issues were taken up again during the discharge talk.

Looking forward

Going home as soon as possible was the desire all ten women had. As mentioned earlier, the length of stay of women in this study after a vaginal birth was between four and six days whereas for those who had a caesarean birth, it was between eight and ten days. Realising they would be left without professional support at home unless they called for it themselves triggered many questions throughout women's stay at the hospital. However, the main interest was directed towards life with their baby at home. Women in this study became aware of the responsibility a baby places upon them and their lack of knowledge in respect of childcare. Self-care issues were raised less often and this corresponded with their expectations. In our final conversation when I asked Kirstin how she felt on the day of discharge, her answer was as follows:

Kirstin: Yes, hmm, - I felt, yeah I felt quite relaxed about it. Hmm, I think because I was thinking for the first four months, I had everything I needed to know and I made sure of that and I have to clean her and I have to change nappies and I have to bath her. Top and tail, the hair, everything, just use water and then, to know about feeding. They said just for the first four months, don't try using, you don't need tea [fluid] or formula or anything just for the first four months, mother's milk, that's what they need. So it's quite simple. So I just made sure that I was for the short term future, I knew everything I needed to know and obviously when I need to know about solid feeding or solids or what, the baby bath then you can go to the parental clinic. So well, it was short term and also if she has temperature for some reason, that's a big problem with me, you know. She certainly gets temperature, what do I do, when do I have to call for help and who do I call sort of things. And I asked all these questions, I've actually forgotten, but I did ask all these questions so I knew everything that I need short term. So I felt, you know, it's not so difficult at this stage, it's just water, milk, sleep, that's it. (K2/1428-1461)

The above excerpt shows that Kirstin's prospect was the short term future. This obviously was important to her but it was also an amount of information that she could feasibly cope with. Similarly other women would clarify their questions with the nurses as it appeared reasonable for them.

Being in hospital was experienced differently by women in this study. It was not only that they knew that this time was coming to an end soon, it was also that they had something to look forward to. Kirstin gave an account of how she experienced the days on the unit when I asked her how those were for her. She explains how structural and environmental aspects interfered with her well-being and prompted her to leave for home:

Kirstin: Terrible – absolutely terrible. I hated being in the hospital, I really hated it, because it was too hot - and – you never got any - any peace, never. It wasn't possible to sleep – and every person I spoke to said the same thing. It just, you never get any peace during the day. You know, you get up and you have breakfast and when you come back you have a shower, it all takes so long and you have to feed and you put her down and then it's visiting time – and then it's lunch – and then – maybe the doctor will come over, or there was something or all babies cry or your baby cries again and – it's the whole night as well. It is, you never got a moment, just as I thought – wow, I can have a little sleep, every single time, something happened, every single time. It was so tiring, also in the night. (...) As soon as I got out of the hospital and got home and relaxed and had a shower and a sleep, no problem. That was the only problem with hospital, no sleep, no rest at all and you need rest – and I think it makes it very stressful – being in hospital – when you can't sleep. That's the worst thing that can happen, really – but – there's nothing you can do. (K2/237-288)

Desperate for her own space Kirstin felt happy being at home. The array of stress factors caused by the day-to-day routine and the structure of the postnatal unit influenced her decision. Other women also decided about discharge because of certain events as we see in Britta's case:

Britta: Because I didn't know if I wanted to go home on Thursday or Friday and then – one night the woman in the next bed needed compresses all night long because of the problems with her breasts and after that I thought, oh no, now I have to go home, then I can sleep. – I mean, nothing against her but I just thought, oh no, now I do want to go home on Thursday – because I just couldn't sleep soundly – you know I was always – was listening with one ear. (B2/645-659)

Intrusion from other women was the reason for Britta to leave the hospital whereas for Alicia, it was her wish to be on her own and to experience her new family. The latter was an expectation she had mentioned in our initial conversation and although they had times as a family in the hospital, the nurses' routine left her feeling crowded. Additionally, autonomy comes into play here from Flavia's side as she felt supervised and inhibited by the professionals. The two following excerpts illustrate these issues:

Alicia: ... yes, it's, ... well it was one reason to go home because I simply felt exposed but it's not – hmm, I think I'm quite sensitive like that, and – they did leave me on my own but it's just – you have ... yes, you're just observed and – yes, ... keep getting interrupted with something – well I simply wanted to be at home and on my own.

Irena: Yes, this was...

Alicia: Wanted to just be the three of us. (A2/851-866)

Flavia reasoned in a similar way:

Flavia: In hospital they know, hmm they know exactly how to do things but at home nobody's watching you all the time – this is just – yes ... or just having time to try things out, yes – or you know in the beginning we did a lot of things together, my partner and me.

Irena: To find out together how it works? (...)

Flavia: Yeah, exactly or you know, they do everything so quickly and you do it so slowly, yes that's it. (F2/270-293)

Such views were reflected by other women as well. The critical recognition of the hospital routine is measured against the amount of learning and need for rest during the time on the postnatal unit. As a consequence the two journeys, which are the journey to motherhood and the journey through the postnatal unit in the early phase post-birth, are in dissonance with each other.

Summary

The emphasis in this chapter is on the postnatal journeys first-time mothers embark on as they enter and pass through the postnatal care unit. Women's journey to motherhood follows the immense emotional and physical impact of birth, but being a mother is at the forefront and this process is not restricted to the liminal phase in hospital. Getting to know the baby and their own needs confronts women with many challenges. To fulfil the nurturing role is a major task, and to learn and to do childcare occupies most time and calls for energy. In this study, some women learned it more easily whereas others struggled to regain strength and to take on the responsibility. Rest and recovery remained an issue throughout their stay on the unit and was not to the satisfaction of women in this study. On the other hand, physical and emotional strength had an impact on their confidence, on how they coped with their situations and how they were able to acquire knowledge and skills.

In contrast, there is the journey through the postnatal care unit with a beginning and an end and the two journeys are inevitably intertwined. Women's well-being and their respective needs determine the length of stay in hospital. Nurses on the postnatal care unit focus strongly on breastfeeding and childcare, which complies with the unit's policy and with women's expectations. The enacted policy of the BFHI provides a guideline which nurses adhere to where possible. However, they were considerate in ensuring that women in this study had their say in how and to what extent they needed sleep, hence what support they needed in this respect.

Nevertheless, self-care issues and women's coping abilities on the other hand were less emphasised and this inevitably had an impact on their adaptation to their new self and their new role. Within this setting, there were several other factors, which did not support a smooth progression. The daily hospital routine and the flow of things in the multi-occupied rooms were very hectic and interfered with the need for quiet times. Nurses made a great effort to respond to women's needs and to provide individual care. However, lack of knowledge and experience, and also personal attitudes towards certain subjects, jeopardised such attempts. Furthermore, limited availability of nursing care caused distress for women as they were put in a dependent position or because it challenged them to do things they were not yet sure of.

The consequence of these contradictions was that although women expressed satisfaction with the received care, they all were looking forward to going home. Whereas this is perceived as normal and desirable there remained a feeling of being overcrowded by the activities on the unit and the data demonstrate this. The attempt to promote a safe and secure environment for women who become mothers for the first time is jeopardised by the condition of this postnatal unit. Further aspects were the fragmentation of care organisation and tensions between professional groups, which were not fully recognised by women.

CHAPTER SIX

CARING RELATIONSHIPS

Introduction

In the previous chapter I explored the first-time mothers' postnatal journeys and the challenges they faced while they were in this 'betwixt and between' phase on the postnatal unit. This provides a background to the present chapter which examines caring relationships between the participating first-time mothers and the nurses allocated to them in the day-to-day processes. The chapter begins with a consideration of the women's expectations and what they believed their needs would be while in postnatal care. It also explores continuity in care provision and this is linked to establishing and maintaining a relationship between the individual women and nurses. Furthermore, the relationship nurses construct with women's partners is examined since this appears to be a significant aspect of postnatal care and makes an important contribution to establishing a new family.

To reiterate, the nurse-patient relationship is central to professional practice (Ramos, 1992) and referring to Swanson's definition (1991) of caring, the relationship to the person cared for is seen as fundamental. It is important to note that I refer to women instead of patients, therefore I have decided to use the term woman-nurse relationship. Likewise it is important to remark that this is not entirely in line with Travelbee (1971) who promotes the idea of talking about a 'human-to-human relationship' as only human beings can relate to each other. In her writing she suggests that a professional relationship is only possible when the interacting individuals perceive one another as human beings and not in their respective roles. The relationship is to be established and maintained by the nurse with the purpose of

meeting the care receiver's needs (Travelbee, 1971). However, in my study establishing a woman-nurse relationship is influenced socio-culturally and by lived experience. As structural and institutional forces also influence the establishment of a relationship, it is crucial to shed light on the interplay of the individuals with those forces.

Weaving the Net

The process of caring for a new first-time mother in the postnatal care setting starts at the moment of admission to the unit. This is comprised of a formal introduction, followed by assessments of the mother-baby dyad at every subsequent encounter. Swanson (1991) argues, the information exchanged and the mutual responses to one another are supposed to form the basis for a caring reciprocal relationship. Whereas nurses are educated to strategically engage in establishing a relationship, most women were inexperienced in the role of a receiver of care, hence experience in establishing a relatedness with professionals in such settings was unfamiliar. Only two women in the study had been hospitalised before, but four of the ten women knew the hospital routine as health care professionals although their experience varied widely. Nevertheless all women had expectations regarding self-care and baby care as became clear during the initial conversations. The emphases were strongly on breastfeeding and learning childcare in order to be prepared for a good start at home. Integration of their partners was mentioned by several women and they expressed that nursing staff would teach them childcare. Yet, self-care issues featured rather insignificantly. When such expectations are brought into this setting, they are crucial determinants of how women engage in a relationship and how they perceive care and evaluate caring outcomes.

The women, when asked what they expected for themselves, pointed to the professionals' expertise. Alicia and Hanna exemplify this:

Irena: What you expressed most was that you'd like to learn something. What other responsibilities do you think nursing staff should assume? What do you think is the area of responsibility for nursing staff?

Alicia: Well, I think – I can imagine that I'm profiting from a professionalism, especially at this time, that I can't find otherwise. Every mother has her experiences, and you can always ask about them, but I think that someone less connected – on a postnatal unit, well, they've seen a lot more. (...) Yes – and to be carried along a bit, you know, over – the – the – I can imagine they have a certain confidence, because they deal with it all the time.

Irena: I see. (...)

Alicia: I think it depends a bit on the situation, if things should turn out more difficult and I don't know what to do, I'd like to have someone to take over, you know, the same sort of things that you [Alicia is referring to me, who she saw as a representative of the postnatal care unit] offer, so you get a chance to get a good night's sleep, you know - I could really see myself - you know, wanting that. But if you feel all right and things are going well, I don't think you want too many people to interfere.

Irena: Hmmm, I see, so that you get your own space.

Alicia: I think it's important to be able to say how much you want. (A1/603-652)

Similarly, Hanna states the following:

Hanna: [It's good when] you can profit from the experience of the women who work there, ... yes and beside that, to have people around, who you can ask questions, you know without feeling worried or inhibited or anything. I just think it's also emotionally, a totally new situation, where, after the feeling of just having given birth to your child and now there's this little human being there and until you've kind of processed that, or integrated it into your emotional life, you might be very sensitive and that they take all that into consideration. (H1/495-511)

These accounts illustrate the importance of the nurses' professional expertise and experience but the level of access to the nurses' knowledge is unknown thus far. There appears some uncertainty in terms of values and norms. Furthermore, there are anticipated needs for emotional care as women seem to be aware of a probable sensitivity post-birth. Consequently, women assume a certain degree of dependency on professionals and consider provision of information and knowledge to be of the utmost importance and beneficial for their confidence. The two women's statements imply the perception of a risk of the unknown as they embark on a new enterprise. Risk is inevitably associated with trust and Carol's account exemplifies this as she refers to trust as the most important element for her:

Carol: You know the most important thing is really that you can trust everybody at that moment. I think, you're already a bit, well, it's like, the intimacy and everything, (...) but the main thing is to trust the professionals, that's what I think. (C1/413-422)

Irena: What do you expect to get from the nurses?

Carol: ... hmm, definitely depending on my condition, that, just that they're there for you, that you can really talk to them. (...) Just all those things that technically we were told about on the course, that it really is how they said, you know, that I can fall back on them.

Irena: So that they don't just make promises, but you actually get what they promise, that's what you expect?

Carol: Yes. (C1/646-680)

Trust, specified in the above excerpt, is also contained in the preceding statements and it shows that creating a high level of trust is necessary in the relationship between women and nurses. Indicating trust as highly important illustrates the apparent dependency and reliance on health care professionals. According to Johns' concept analysis of trust (1996) the prerequisites for entering a trustful relationship are the beliefs that the professionals are sufficiently competent, reliable and trustworthy. Zweifel and Breyer (1997) also argue that in an exceptional situation such as in illness, a person might not be capable of rational decision-making, and hence might depend on relatives or professionals to assist in the best possible way. Despite the debate about whether childbearing women are considered patients, women in this study expect to be vulnerable, and hence consider themselves as dependent on professionals. Trust therefore becomes pivotal as prenatally participating women were uncertain of what to expect in terms of birth and its outcome. As Morse (1991) indicates, trust is built progressively and is fragile. That is, trust refers to highly complex forms of woman-nurse relations as well as mundane processes, which are necessary for the generation and maintenance of the caring process.

With a lack of prior or relevant experience in similar situations, women in this study verbalize what support they might need. Diana's expectations are related to what she thinks is important to her for the time at home:

Diana: [What's important to me] is just that I'm prepared for – for what I'll have to do later. Just about how, um...well, just everything about childcare. To get all the necessary information there, um, - how to do things and what you have to do, that's important to me. But most of all just the rest and – information about childcare and ... yes, I think they're the most essential things ... hmmm, and this is, you know when I come home, to know, yes to have a sense of security, to know how to handle the baby and what I have to pay attention to. (D1/1060-1077)

This data excerpt indicates that the time on the unit is liminal. However, this time is perceived as an opportunity to learn for what is coming. Moreover, this statement emphasises childcare and that acquiring security in this respect is important. Nevertheless, rest is mentioned, an aspect that points to self-care. Uncertainty of what might be important for themselves was brought forward by several women in

this study. The next excerpt from Flavia's data set shows her reservation in this respect:

Flavia: Well, I don't know myself exactly what I'll need from them, just some support from the nurses, yes.

Irena: When you say support...

Flavia: Well, more for the baby – I don't necessarily expect that they'll spend a lot of time with me – as I would prefer to discuss things with my partner, yes. (F1/1051-1062)

What becomes clear from the above excerpt is the distinction made between childcare and self-care. By its very nature women's expectations are childcare specific due to their lack of knowledge and skills. Aspects of self-care and of human relations are secondary as they disparage their own needs to some extent. It can be concluded that women conceptualise care for themselves through caring for their babies. However, and as proposed by Rubin (1975) and Cudmore (1997), a new mother needs to be comforted to successfully complete the transition to motherhood as she can only then develop her potential caring for her baby.

Whereas provision of practical care is seen as the function of nursing, sensitive issues need to be discussed in a protected atmosphere – the significance of the partner's role in that respect is highlighted in Flavia's statement. This implies that emotional care provided by people the women can already relate to, such as the partner, is preferred. Yet, in the following excerpt emotional care for the first-time mother is emphasised and considered as a function of nursing. Giovanna presented the following answer when I asked her what expectations she had:

Giovanna: Well, I think the interpersonal area, you know because you're so sensitive and I hope, hmm, yes, that the nurses – the way they treat you, well, that it's just a bit, I don't know how to put it exactly – that there's just an understanding there that it's a new situation for you, and I get the impression, from the management you know, it's pretty good. You know, like the handing over and that the doctors don't do their rounds any more, unless you really need them, things like that – I find it all - good. So that's one condition, but beside that, I'm sure it depends a lot on the nurse what you get, that's another thing. (G1/738-755)

This statement leads to the belief that a positive outcome depends on the allocated nurse and how she establishes a relationship with the woman. The personal dimension of the woman-nurse relationship is indicated and it also points to the unknown that such a situation might contain. Further this statement illustrates an awareness that institutional structure influences human relations, hence affecting care

provision. In this respect, authority as an external element influences the woman-nurse relationship.

Taking all examples together a wide range of expectations is demonstrated. Not every woman would cover all of those aspects in the initial conversation. Nevertheless it is significant that all five caring processes described by Swanson (1991; 1993) feature in the overall expectations of women in this study. As already mentioned, the state of high vulnerability demands presence on an emotional level, hence 'being with' and 'maintaining belief' in their ability to successfully get through this life event is essential. Understanding their unique situation and providing knowledge is inherent in the caring process of 'knowing'. 'Doing for' as a therapeutic action is central to women's expectations, although in this process communicative actions are equally important. As women are aware of the short term stay on the postnatal unit, 'enabling' to care for them and their babies is a crucial requirement since they are left without structurally provided professional support at home.

Women's expectations fundamentally influence the woman-nurse relationship and caring outcomes. From this viewpoint the following sections examine the caring approach in the postnatal setting and how nurses establish a relationship with the women they care for as was observed in the dyads.

Getting to know one another

During the initial encounter, nurses conduct a physical assessment and enquire about the basic needs of women and babies. In their conversations I could hear the nurses inquiring about the recent experience of birth and pregnancy. The extent of such conversations depended on time, availability of the nurse and well-being of mother and baby. Although this first encounter is important for a positive start in the caring relationship, assessment is an ongoing process and does not stop until the moment of discharge. 'Knowing' as one caring process is enhanced through those caring activities. The goal of the assessment procedure is to get to know women's expectations of care, their needs and what they anticipate learning while on the unit.

In the conversation I had with the participating nurses they mentioned their caring relationship with women and how they perceived their involvement. Women on the other hand were more general in this respect. One reason for this might lie in the time frame in which those reflective conversations took place. Since I was talking with the participating staff members after the end of their shifts with some exceptions, the memories of the actions were very vivid, whereas with women the reflection was some weeks after discharge. In the following example, midwifery student Simona describes how she was able to relate to Liana when she was caring for her:

Simona: I did feel like, specifically with her, I had an easy, well from the beginning a relaxed relationship. Maybe because of our age, no idea, or just, I think she felt fairly comfortable there because she'd worked there before. She mentioned that to me right away and because of that it somehow, it was just right.

Irena: Did things just click between you?

Simona: It's not the same with every woman, no – definitely not and also because it was so unproblematic with her. She really only needed, you know, help with breastfeeding and not any other major problems – you know additional things. I think that really made it. (L5/62-83)

This excerpt displays only a few of the many factors, which support the establishment of a constructive relationship. Interestingly she illuminates aspects from both sides, which shows the importance of mutuality and how this resulted in feeling comfortable with the women. Other nurses describe how they perceived their involvement in caring for women in this study on their first allocation. Firstly, Nurse Maja, allocated to Hanna:

Maja: I haven't had so much time recently, especially on the first day, when it would maybe be important. Yes, then you maybe don't speak as much, but I think I could definitely still build up a relationship with her. (H3/486-493)

Nurse Angela, caring for Diana, summed it up as follows:

Angela: There's, I'd say that very little has come from her side. I know it's difficult when someone's new, people sometimes need some time to, um, get acclimatised or something. She might open up on the second day.

Irena: Do you have her again tomorrow?

Angela: Yes, I'm working six days in a row now.

Irena: Okay, then it's possible to keep working on that.

Angela: Yes – and I can't quite get a feel for her as a person. Maybe she's someone who doesn't really say what she wants, that might be it as well – but I don't know for sure, I really don't know her that well. (D4/306-328)

From the above, it can be seen that managing the relationship was of importance to these nurses. In assessing women's behaviour and judging their responses they evaluate how they connect with the person. Although both nurses were allocated to those women on their first shift on the rota their perception was very different. Whereas the first example marks openness, the second demonstrates uncertainty about how they would connect. The time issue brought up as important in establishing a relationship has implications for the quality of care. In the latter, there is an indication that time will bring Nurse Angela closer "to dealing with the 'whole person'" as Barker (1997:5) explains. Nurses tend to work towards an ideal of valuing the individual and this requires time.

Additionally, knowledge and confidence are factors influencing how nurses engage with women. This next comment from Nurse Carla attests to the lack of both as being allocated to a first-time mother was a new experience for her:

Carla: Hmm, yes – when I reflected on it, I realised this was the first time I had been allocated to a first-time mother in that early stage, hmm, and I also noticed that I felt a bit unsure of myself with her care, hmm, - a bit unsure of things like how much information can she cope with already, how much is necessary, what's unnecessary, what shall I give her now. I was glad to have another day to get to know her better. (...) I was thinking, she's here for five days, pretty definitely, what's appropriate on this very first day when everything's so new.

Irena: What's the right amount in this situation, or the right support, the usual – mmh – and you said you felt a bit unsure of yourself.

Carla: Yes – also with things like, when can I leave the decision to her, or when do I make clear suggestions that she can say yes or no to? When can I leave it open and where do I give her clear guidance? (B3/36-71)

Central in this excerpt is the influence of little experience and how confident the nurse felt in that particular caring situation. Although an experienced nurse in other fields, she was a novice to postnatal care as she was only appointed two months before this observation took place. Carla requested supervision from an experienced nurse whenever she felt insecure during the shift since she was committed to giving the best possible care. Reflection on her caring behaviour helped her to acquire more competence for the next shift. Hence, 'knowing' was essential for attending to this woman in the best possible way. This data excerpt shows neatly situated learning by doing, and it shows how meaning, knowing, acting and learning are interdependent. During our conversation, which took place the day after the observation, the nurse ruminates about her experience in this situation, how the woman responded to the

caring interventions and how she could improve her performance. Sharing her experience, feelings and thoughts contributes to increased self-awareness and according to Pierson (1998:169) “individuals engaged in sincere efforts to reflect are vulnerable”, yet shared vulnerability facilitates development of trust. The author reasons further that trust develops slowly within an atmosphere of mutual respect. The next section explores trust and how it affects the caring relationship.

Starting to trust

In a caring context where interventions aim to meet women’s needs and contribute to their well-being, it is important to create and maintain a sense of trust. Trust was expressed by women as an expectation and this issue was also discussed in the preceding chapter in relation to how women trust in nurses’ competence. In this section trust features as an attribute and the way it contributes to the caring relationship is discussed. Although not immediately tangible every encounter and conversation helps to prepare the ground for a relationship. However, the level of confidence on both sides influences how and to what extent two people can relate to each other.

In respect of a caring relationship some sharing of personal information at the onset helps women to relate to the nurse and as I observed women often asked for more details later on. Questions raised, for example, were if the nurse was a mother or for how long she had been working on that unit. Such behaviour was made obvious in Morse’s study (1991) about negotiating commitment and involvement in the nurse-patient relationship. She states that in the process of negotiating a relationship, patients gradually assess the nurse by watching her, asking personal questions, estimating her performance and testing her trustworthiness. On the other hand nurses themselves revealed personal information as the following excerpt from the conversation with Nurse Barbara shows:

Irena: You said to her that you knew from your own experience with breastfeeding that it hurts. Would you say that to other women as well, you know that you can say this from your own experience?

Barbara: Yes, I say it now and again, yes, I say it now and again. And specifically in connection with breastfeeding I’ve often realised that women don’t know it and it’s not written anywhere either. (K3/338-352)

When breastfeeding was becoming very challenging for Kirstin reliance on the nurse's help increased. Morse (1991:460) explains, "the more threatening the situation, the greater the patient's dependence on the nurse". During that late shift, Kirstin relinquished herself to a patient's role and relied on Barbara's help with breastfeeding, expressing milk and soothing the baby. At a point, the nurse explained that latching on often causes discomfort or even pain if nipples are cracked or sore. In this situation, Barbara also revealed her personal experience of breastfeeding her own children and how she felt pain. I observed how Kirstin seemed relieved by this explanation and how the two related to each other on a personal level. According to Carper's conceptualisation of nursing knowledge (1978) personal knowledge is one component and it enhances professional competence. Consequently professional expertise profits from personal knowledge and is enhanced by it.

Later, I could hear the woman praising the nurse for her perseverance and as Barbara later said, this was the best compliment she could have paid her. This brief statement exemplifies the intimate level of the encounter between the two people and the seed of trust, which facilitates the development of a relationship.

Another statement from Nurse Carla shows what influenced her relationship with Britta:

Carla: We were both learning in this new situation and I think that got expressed as well. You know I had the feeling we both were rather tense and I was really happy to have one more day as things got more relaxed. (...) Yes, there was more of a basis for trust, or it basically became more relaxed – hmm – from both sides. (B3/451-474)

This critical comment of this staff nurse provides a useful insight into how she perceived mutual learning and how she understood the development of the relationship over two days with this woman. In a short period of time, she felt herself grow in confidence, which resulted in feeling more relaxed in this caring situation. Diana, another woman in this study describes how she felt cared for by Nurse Angela:

Diana: Well, Angela I thought, she was a very competent nurse and she really took a lot of time and hmm, yes – yes just to explain things to me over and over again and helped, not only about breastfeeding, apart from that as well. Yes – hmm ... well, when I got home, then I had the information I needed, yes I was as far on I wanted to be. (D2/1574-1587)

This is an excellent example, pulling together significant points, of what made this woman feel confident. 'Enabling' features prominently but moreover the combination of sound clinical competence, enough time and satisfactory provision of information contributed to a positive outcome. Although it was not clearly stated it could be concluded that in this caring relationship Diana felt perceived as a human being since her needs were fully met. To rephrase this in Morse's words (1991), patients felt grateful when their experiences and their needs were recognised by the nurse and prompted a affirmative response, hence they would trust the nurse. A different view is presented in the following statement:

Alicia: Well, foremost, it was the uncertainty of the student nurse. For example, with that stupid venflon® [venous cannula]. When I said, this could go, she said she would have to ask first, because the 24 hours weren't up, you know? But I thought to myself, I'm sure this could go. Later she came back and says – yes, it's alright. (...) she didn't know what to do next, and this happened a couple of times, little things like that. (A2/609-624)

Considerable doubt about the student nurse's competence is expressed in the above statement. Although referring primarily to technical competences this might well affect the woman's sense of being cared for on an emotional level. In the course of my observation, nursing and midwifery students were allocated to women during several shifts. Although they had a supervisor in the background they were mainly working on their own, seeking help or advice in cases of obvious and realised uncertainty. Women were sensibly aware of that as I heard in our final conversations. Student nurse Larissa, to whom Alicia in the above statement was referring, describes the situation as follows:

Larissa: I feel I've been able to build up the relationship today. Perhaps it's, well it's one more day, we've got to know each other better. – And because of that, I feel our relationship's grown and - I also feel she's got more self-confidence now. She said some things spontaneously, she seemed more cheerful too, it might be because she's about to go home as well, that might have played a role too. And then, communication, I've found it quite easy to get talking to her, to discuss things. And again in today's talk, during the assessment too - I got a lot more out of her this time.

Irena: Did you?

Larissa: Yeah, you know, she's become more open, generally speaking, and towards me as well, and maybe I was able to relate to her in a different way today, since she opened up quite a bit and we knew, or had got to know each other better.

Irena: So ... well, yesterday you said something about the new situation making things more difficult as far as establishing a rapport is concerned.

Larissa: Yes, definitely. (...)

Irena: Hmm, you mentioned the situation with the GT [Guthrie Test], how was that for you?

Larissa: To me, it didn't make much of a difference to have to prick her [the baby] twice. - But I then realised that the mummy wasn't happy about it, and it bothered her and the dad too, which is understandable. And in the end I did start asking myself if I could have done it differently - you know, with hindsight ... but it's done now, you know. (A4/11-76)

This interview excerpt demonstrates instability in this relationship as the nurse is distancing herself in this last section. In the first part a certain closeness materialises whereas in the later, emotional withdrawal appears. Obviously, the parents were distressed watching how the nurse was causing pain by doing the heel prick twice. As the woman had already been critical of the nurse's competence, the level of trust diminished further with this intervention. In the situation presented, Larissa seemed to realise the tension, hence she could not remain present emotionally. In response to her failure to perform competently in this caring situation, she covers up with a nervous laugh. Larissa's behaviour in this situation shows her vulnerability.

In short, the intention to establish a woman-nurse relationship is a need for both, women and nurses, although women were not commonly aware of this before their hospitalisation. Of the many factors facilitating a trustful relationship, nurses' competence and available time were most important. Relating on a personal level seemed important to nurses but it is also shown that confidence and trust are inevitably linked to a trustful caring relationship. This demonstrates the influence of professional and structural conditions on the collaboration, hence their effects on the caring outcome. Women's and nurses' evaluation of care was also based on the awareness of consistent and continuous care provision, which will be examined in the next section.

Keeping the Thread

One concept supporting and maintaining a trustful caring relationship is continuity in the caring process. All women in the study hoped for the best available care during childbirth and postnatally, hence competence and individual care were frequently mentioned. Continuity in the caring process was not an explicit issue in our initial

conversations, however, a comment made by Alicia does reference the concept: “you know, like being carried along a bit” (A1/618-619). Such an expression indicates a belief that emotional care is unlikely to be a one-off event but rather a continuous process requiring knowledge and perseverance in helping women to get through this life event.

Both continuity of care and continuity of carers are thought to contribute to a satisfactory caring outcome. Nevertheless in a structured literature review about continuity of carer, Green *et al.* (2000) state that what women want most is consistent care and a woman-centred care approach. Care is considered consistent when professionals demonstrate good communication and adhere to a consistent policy. Care given by only one person is regarded as total continuity of carer (Green *et al.*, 2000). As mentioned in Chapter Four, fragmentation of care during the three phases of childbearing is the norm in this setting. Since my data refer only to the postnatal phase, the following section considers continuity of the caring process of this phase only.

Being in touch

The establishment of a woman-nurse relationship involves relating and responding to the woman’s experiences and her needs. As nurses were concerned about ‘knowing’ women in order to provide the best possible care, they appreciated a continuous allocation. This was inevitably related to job satisfaction but they also believed it was better for the women for whom they were caring. Nurse Jennifer’s rota allowed an assignment during early shift for Flavia’s entire time in hospital. Her view is as follows.

Jennifer: Well, she gave me some feedback and said it was very good for her to have the same nurse for these days. That’s quite rare, you know, that it works out like that for a woman on this unit although we sometimes work rotas of five, six or seven days. But it all worked very well, and it was rewarding to hear it because I like to work like that. The provision of care is optimal and you can really keep at it and you know what goes on in-between. You know you’re never really able to get the real information from the documents or if your mind wanders a bit when someone’s telling you something, because there’s so many other things you have to listen to and think about at the same time. From that point of view, it’s a tremendous relief for the care.

Irena: She made it very clear that she appreciated that.

Jennifer: Yes, also for me – yes.

Irena: That something could sort of grow between the two of you.

Jennifer: Yes, it's as I said, it makes the caring rewarding because you know, well, it rounds it off. (F4/553-586)

From this reading, it can be concluded that a constant allocation promotes the provision of woman-centred care. In spite of that, a continuous assessment is necessary since written or verbally transmitted information is likely to be incomplete. Furthermore, Nurse Jennifer's account shows clearly that she evaluated the caring situation as satisfactory and rewarding. Mutuality in this issue is in evidence in the statement Flavia made when asked what she thought of her care provision:

Flavia: I felt, um, that they really took me seriously, I mean, really, she really had a complete picture somehow, of being a human being, being a mother, being a woman, something like that, and I felt that was really good, I really think that belongs to it too, just so things come full circle. (F2/1078-1086)

The continuous allocation of the nurse in this situation is qualified as individualised care and was fully appreciated by the woman. In the expression "things come full circle", lies a sense of holism, an aspiration central to nursing. However, Green *et al.* (2000) state, women do not appraise continuity for its own sake. They would rather have "consistent care from someone whom they can trust" (Green *et al.*, 2000:195). From what is expressed in the above statements it can be said that Flavia and Jennifer were able to enter a trustful relationship. Therefore Swanson's five caring processes (1991; 1993) were brought to life in this caring situation.

Similarly to Flavia, another woman commented on the subject of continuity of carer. Carol stayed in hospital for nine days after a caesarean birth and she says the following:

Irena: How did the nurses respond to your emotional situation?

Carol: Well, very concerned and understanding. They were really, when they had the feeling that something was up, I mean I said myself when something bothered me or whatever, either they realised it and I didn't want to talk about it, or they did it themselves. Somehow it was really lovely, you know they were so kind and they really took care of you somehow ... yes truly, well those three women. Well they took turns as it were.

Irena: Was it mostly those three women who were with you during that time?

Carol: Right, yes those three, and I thought Ladina was the biggest treasure, she was somehow, how can I put this, she was quite extreme somehow, you almost had to be careful with her, that things didn't go too close to the bone. For example, she told me she'd like to have children too, or that Sunday when she spoke to my husband and me, somehow it really affected her. She almost had tears in her eyes herself, she makes such

an effort to make sure that all the patients are alright, the well-being, she really looks out for that and somehow she almost needs to be careful herself that things don't get too close or somehow to distance herself. I noticed that what she'd most like is to care for everybody, to be there for everybody, yes. (C2/1482-1530)

As this statement presents, care provided by three nurses was perceived as continuous and resulted in satisfaction with the received care. However, Green *et al.* (2000) suggest caution in drawing a generalised conclusion because of a lack of research evidence that continuity of care inevitably leads to higher satisfaction. Nevertheless, Carol still remembered the names of the three nurses in our final conversation and she referred to each of them in relation to specific subjects. Walsh (1999), although researching midwifery care, states that women remembered midwives' names and referred to them, but only if they were delighted with their care.

In the last part of Carol's account an indication of intensive emotional involvement (Travelbee, 1971) in the nurse's behaviour is described. Morse (1991) argues that such behaviour can be unhelpful. However, and as described in Chapter Five, the outcome of this intervention was successful in that the nurse was able to soothe the baby and to convey confidence to the parents. Since I observed this particular situation, I asked Nurse Ladina how she was able to relate to the woman:

Ladina: Well I feel that I've got a good connection to her, or I've got a connection, and it's good, but we'll have to see what and to what extent she tells me things. I'm interested to see how tomorrow goes. (...) But yes, I sense she's accepting me. (C3/593-603)

'Being with' the parents as they experienced a stressful situation with their baby turned out to be a key incident. Furthermore, this brief statement supports the notion of establishing a relationship over time. To engage in a caring relationship involves employing emotional presence to adequately assess and respond to needs. Because this was at the onset of Carol's stay in hospital such an experience could have been essential to exploring and developing a relationship. In the statement above, Ladina is looking forward to the days to come with a positive attitude.

Nurse Helena was another of the three nurses caring for Carol. She describes how she perceived working with her:

Helena: It was very good for me to be able to compare how it was at the weekend and how it is now [Thursday]. I think it's really satisfactory for her now, you know the way it all developed.

Irena: Yes.

Helena: And for me, it gives me a good feeling too, really. When I came back yesterday, she wasn't well at all – she cried and things just weren't right – and so we just made yesterday a day off. Just to look after herself and breastfeed and that's all. And this morning, I checked with her how she felt – and she said she feels much better. (C5/20-43)

With a continuous allocation to the same woman over days, the nurse found a point of reference through which she could assess the woman's well-being. As a result, attendance to her emotional needs featured more prominently. Again in this example, job satisfaction was expressed as the nurse evaluated a positive caring outcome on the grounds of the woman's response, and as shown earlier this was approved by the respective woman. Stability in care provision is likely to result in job satisfaction. However, there are other influencing factors, for example Adams and Bond (2003b) find a link between care processes and care ethos of a unit resulting in job satisfaction.

Contrary to the above statements, the following account from Kirstin sheds light on discontinuity of carers:

Kirstin: Mmm, I found that very strange, it wasn't a problem because, ehm and this sounds a bit like kissing their feet or whatever, but they were all so nice. There wasn't any nurse that I thought, she was, hope she doesn't come back. (...) But I thought it's strange, are they not able, ehm, to assign the same nurses to the same woman for a length of time. I couldn't believe it. Every, I mean, I think I had two or three, twice or three times maybe and then every day a new face, every single day and they have to get used to you and the fact, maybe I'm very tearful and they're not paying any attention to me because that's just the way I am and I knew somebody new would come in and I think, the communication between the nurses was very, very good. The way that they came round at the beginning of a new shift and went through everything and if I asked one nurse something, it would always be passed on to the next shift. It was very good in that sense, but ehm, in a sense, you know, the new nurse would, I don't know maybe sort of not really understand certain things about – the other nurse did, because she's been there for longer.

Irena: Right.

Kirstin: And that was sort of, I found that very strange, really didn't understand how they couldn't organise, that was the one thing, that I thought was rather badly organised, because it can be unsettling for certain women, I think. As I said, for me it wasn't a problem, really wasn't, but you know, to have so many different faces, I think it's more room for – hmm mistakes maybe, or misunderstandings.

Irena: Mmm.

Kirstin: Always that change of shift and obviously they, although they kind of did things the same way and as I just said, there wasn't a great, there is no change in technique doing this, which is an advantage as I said before. You know the technique, but very strange, very strange indeed. (K2/1286-1349)

This extensive account presents a contrast to the two former accounts in relation to continuity of carer. I witnessed a conversation between Kirstin and a nurse on the subject of continuous allocation and both expressed their concerns about it. As it became clear here, although not dissatisfied with the care in general, the woman disapproved strongly of the inconsistent nurse allocation strategy. Nevertheless she stated quite convincingly that consistent care was delivered throughout her ten-day stay at the hospital. This is in line with the claim of Green *et al.* (2000) that continuity of care depends rather on a shared policy than a consistent allocation of carers.

Although presenting satisfaction, Kirstin's statement entails a critique of the allocation policy. As demonstrated elsewhere, to openly express dissatisfaction with received care seemed difficult for women. A question remains as to whether women reciprocated good care by protecting the nurses from criticism about aspects of their care in the unit. In referring to the constant changes of face and the lack of consistency in allocated nurses, Kirstin implies a lack of emotional attention and thus queries nurses' competence. According to Attree (2001a), evaluation of quality care by recipients places importance on the interactional and interpersonal aspects. Her study showed the characteristics of good quality care were individualised, patient-centred and need-related. Women in this study were able to assess such outcomes from their individual perspective. Such care, as Attree (2001a:456) further reasons, "was provided humanistically, through the presence of a caring relationship by staff who demonstrated involvement, commitment and concern".

Dissatisfaction with her allocation was expressed by student nurse Laura as she was assigned to Hanna for the first time on the woman's day of discharge. She gives details about the disadvantages entailed:

Laura: I always find it difficult when you take over women on the day they go home and it's even more difficult if a problem crops up as well, I find it very difficult to build up a relationship. Usually I don't have problems with that, but – with her, I really don't know, I can't quite figure it out. I don't think I have a bad relationship but I never know what they think of me because the other nurse always comes along. I don't know if they feel that I'm taking good enough care of them or not. I haven't had the impression that they felt badly looked after but you never know exactly, you know. (H4/503-522)

As is obvious from the above, developing a relationship is dependent on a certain degree of relatedness which can allow nurses to make a connection with women and

so feel in control of their care. While nursing and midwifery students are occupied with acquiring new skills there is often little space to engage in a close relationship. As it transpired throughout that morning, the complexity of this caring situation exceeded the student nurse's capacity to be responsible for Hanna's care. Consequently, she was frequently accompanied by her supervisor and on occasion also by the lactation consultant. The complexity of the situation, the inability to take over responsibility as well as the interference from others caused bewilderment for the student nurse and dissatisfaction resulted. In this context, Morse (1991) notes that the establishment of a connected relationship can be interrupted by specialists, even within the profession.

When asked if there were any indications from Hanna which might suggest that the relationship was thought to be unsatisfactory, Laura focuses on her experience of being supervised:

Laura: Well, when you only have someone for a day and – I couldn't really care for her, really attend fully to her because there were always other people getting involved too.

Irena: I see.

Laura: And mostly because another person was always interfering, so to speak. Well, usually I work more independently and have more time to get involved with the women – to have conversations and – well, just to look after them, properly look after them.

Irena: Yes.

Laura: And um ... for me, I think it's related to how I was supervised. I'm used to something else in terms of being supervised, but – that's why I felt I couldn't quite relate to her.

Irena: Hmm – just so I understand this right, when you say 'something else', do you mean more relaxed or more intensive or what?

Laura: No, - yes, no, hmm – yes more relaxed depending on how stressful the situation is, but in terms of competence, you know [her supervisor's] clinical competence. I got the impression she herself was insecure. (H4/562-600)

There appears a relationship factor between the student nurse and her supervisor. In the course of our conversation she first considered her connection with the woman and her partner and how they might have perceived her, whereas later, she disclosed her feelings about how she was supervised. As mentioned in earlier sections of this chapter, midwifery and nursing students, and also inexperienced nurses, were supervised by an experienced staff member. Although all students had an assigned mentor, they would more often work with an experienced nurse. In the light of effective learning, circumstances like those described above raise the issue of how

students are enabled to improve their clinical skills and enhance their experience. Clinical supervisors, though in the literature more often referred to as mentors, are supposed:

to support students in the clinical area, act as a role model, facilitate the student's clinical learning experiences on the placement, undertake clinical teaching, supervise the student's work so as to ensure the quality of care and the safety of all concerned, and assess the student's practice on that placement (Lloyd Jones *et al.*, 2001:152).

The union of all the above mentioned competencies requires sound experiences as a nurse as well as educational and teaching skills. What emerged from Laura's statement was a patronising behaviour on the part of her supervisor due to lack of competence, rather than the creation of a learning atmosphere. However, one could argue since health care professionals are providing care for the women, the priority must be given to them and not to the student. This argument is taken up by Lloyd Jones *et al.* (2001) who argue that when a qualified member of staff is supervising students they would focus on patient-related than on education-related activities. However, such an attitude is detrimental for students since learning to care is the aim of their placement. An experience like Laura's situation above is likely to have an effect on personal growth, confidence and self-esteem.

As I witnessed the reported situation on Hanna's last day in hospital I was interested to hear how she had perceived it. However, the woman revealed no concerns about nurses' allocation.

Hanna: Yeah, all of a sudden there were a lot of people standing around my bed. (H2/436-438) (...) Well I thought they were very considerate. Yes I could perceive that we, mother and baby, are very much the centre of attention and everything else follows from there, that's how I experienced it, and I never felt under pressure from the nurses, you know that you had to do something or hurry up. (H2/579-588)

Instead, Hanna's statement emphasises attendance to her needs from competent professionals. Furthermore, she approves of a woman-centred care approach and consistency in care provision. What also materialises is a sense of freedom to determine her pace, which was essentially concerning difficulties with breastfeeding occurring at the same time as the event of discharge.

The accounts taken from Hanna's data set display a differing awareness of the importance of relatedness. Whereas Hanna approves of competent and consistent care the student nurse's concern is with relationship. While learning in this situation

appeared to be of secondary importance, I would argue that Laura's emphasis on relationship might well have been determined by a lack of self-confidence in her skills and caring abilities. Such a situation required sensitive teaching and shared reflection to successfully enhance the student's competence, as discussed earlier.

The preceding statements indicate a very diverse implementation of the allocation policy. In this respect women as well as nurses reviewed provision of care critically. It has become clear that the caring relationship benefits from a continuous allocation as it enhances knowing the woman and her needs, hence it is satisfactory for women and nurses. Consistency in care provision was likewise acceptable to women but disruption was noticed and there is an indication that inconsistency causes frustration. The next section considers caring processes and how they contribute to maintaining a caring relationship.

Providing secure care

Provision of good quality care, as the guidelines state, is the target of postnatal care. Since in-hospital care for women after an uncomplicated vaginal birth is still up to five days, or longer in case of a caesarean birth or health problems, care provision is timed over this period to best prepare new mothers for their duties at home. However, staff shortage and staff instability, young and inexperienced nurses and educational responsibilities lead to constraints and limit individualised care, reducing it to standardised care. Additionally, work stress caused by high occupancy and high turnover of women compromises the level of quality care provision.

Professional experience in postnatal care is an important factor in providing satisfactory care. Nurse Leah, newly qualified and only recently appointed to the unit, was allocated to Britta on the third day post-birth. She concurs with this:

Irena: Just say how yesterday was for you.

Leah: Yes, hmm, somehow a bit strange because I wasn't really – or because I realised I can't offer the things that I want to – yes, in that sense. Because I'm still not quite into it, you know what they tell women here and what they think is important, and because it's been a while since I've worked on a postnatal unit and this was in my first year as a student. (B4/3-15)

Considerable insecurity in her competence to provide satisfying care is expressed in her statement. Although insufficiently experienced Leah sets a standard and measures her satisfaction to that level. In certain situations, lack of knowledge led to incomplete or incorrect information. The next quote is taken from Eleonora's data but with the same nurse:

Irena: You had a lengthy discussion about ...

Leah: Yes, about this medication.

Irena: I got the impression that neither of you quite understand what the issue is. (...)

Leah: Yes, it was a bit like that, especially at first. (...) And from my side I didn't want to get any further into it because I realised I wasn't quite sure what to say. That's why I said I'd clarify it first and then come back and discuss it with her and make sure that we both understand each other. (E4/90-125)

This is an example of how the nurse realises her insufficient knowledge background in the course of the discharge talk. Leah found she was unable to satisfactorily explain the intake and effect of medication. Instead of letting the situation go astray she recognised the importance of clarifying the subject and not leaving the woman with incorrect or incomplete answers.

Nurse Fabienne, experienced but under immense work stress, felt the care she had provided was unsatisfactory in the situation with Giovanna:

Irena: Is there anything else about her ... or her care?

Fabienne: Hmm, well, I didn't have a lot of time – yes – because I had four other women besides her.

Irena: Did you think she could have done with more time this morning? Or do you have the impression you neglected her?

Fabienne: No, not really. I told her that we're very busy and that there are only three of us on the unit. Her immediate reaction was, yes, it's good to know that – hmm. No, it's just that I thought it would have been nice if we could have done the assessment interview with her, to get to know more about her as well.

Irena: That still needs to be done?

Fabienne: Yes.

Irena: But going on what she said this morning, she got what she needed from you. (...)

Fabienne: I think breastfeeding is important to her too, that she can – I mean, she'd like that to work too, especially because she's allergic to so many medicines. That's definitely very important for her, that she gets support with that. (G3/698-740)

A similar statement was made by Anja, another experienced nurse, who cared for Liana during an early shift:

Irena: How's the relationship going with her?

Anja: It was still a bit difficult, you know because I felt like I didn't really have much time. (...) She never had a proper assessment interview, there were just a few things noted down. Yes and for me, I would have liked to have had more time for her.

Irena: And do you think that would have been good for her?

Anja: Not necessarily, no. I think, I believe her, she's doing fine, that's what I thought ... you know she wants to go home tomorrow – yes and I think everything's going to be fine, when she goes home. (L4/145-169)

These statements lead to the belief that available time results in job satisfaction and not enough time increases stress. Both nurses had to cope with a heavy workload, and additionally, with other commitments such as supervising students as is usually the case for experienced nurses. If little time was spent with women, their given care was qualified as unsatisfactory. With women's needs in perspective, both nurses reported a satisfactorily caring outcome based on their perception. As a result, the amount of time spent with women is taken as a measurement of quality care rather than women's satisfaction. This demonstrates the complexity of auditing quality care provision. Yet, job satisfaction is pivotal since satisfied staff are more likely to be retained in the work force and as Adams and Bond (2003a) further reason, receivers of care as well as the health care system clearly benefit from staff who enjoy their work.

What is significant in Nurse Fabienne's and Nurse Anja's statements above is the reference they each make to missing the assessment interviews which form a basis for individual care provision. Assessing women and babies is an ongoing process, but as described in Chapter Four, the unit's policy prescribes, in addition, a formal assessment interview, conducted in the early days when women are admitted to the unit. Information is to be obtained in correspondence with the situation of first-time mothers, this assists the nurses in 'knowing' women's needs and hence, influences the care-planning process. Barker (1997) reasons that care interventions ought to respond to experiences produced by the illness process on the person. Assessing is listening to and learning from the person and he further claims it "is much more important than any intervention which might follow" (Barker, 1997:313). Missing out on a thorough assessment is likely to result in routinised care unless nurses manage to individually assess women's needs and expectations at the beginning and throughout each shift. It appeared that experienced nurses in this study coped better with such conditions whereas less experienced nurses and students were more

comfortable with a set of standard or routinised care if they lacked essential information. When I was observing Alicia and student nurse Larissa, I became aware that the interventions were not based on a sound assessment. There were several situations which I raised in the conversation with Larissa. Her reasoning was as follows:

Larissa: Maybe these are just needs that I think she has, (...) but I did feel she needed that. (A3/149-153)

Interventions based only on the nurse's perception can be inadequate. To reach a mutual understanding and to arrive at cooperation, shared agreement on the course of action is essential. Care documentation is another useful instrument for providing information for a first contact with women, although there is no guarantee that documented information is adequate to the women's situation, nor that it will be read and interpreted correctly in order to provide appropriate interventions.

Appropriate care provision also depends on women's ability to express their needs as we see in the following interview excerpt from Nurse Angela after an early shift with Diana:

Angela: Everything came from my side. She's never, but maybe it's difficult for her – she might not know what kinds of wishes she could express, you know. Even if she'd just said something like "it's still painful, what else can you do," then it would be coming from her, but there was just so little coming from her. (...) When I don't get clear responses it makes me feel insecure. It's much easier to respond to somebody who expresses herself clearly. (D4/958-1015)

What surfaces is an asynchrony between the nurse and the woman. Morse (1991:456) identifies such interactions as a "unilateral relationship" in which contact on a clinical level is maintained. Competent technical care provision is likely but the nurse's response leads to the belief that emotional care was missing, which resulted in uncertainty. 'Knowing' requires information about the woman, and demands engagement in a conversation which would enable the woman to become aware of her needs and to express them. As noted earlier in this chapter, Diana approved of Angela's competence and expressed her satisfaction with the received care. This brings out the importance of the timescale in establishing a relationship but also that 'being with' the woman was essential as this helped with fostering confidence.

Nurse Sanna gives an account of what she experienced with Carol when she was teaching her breast massage. She discovered that Carol had received different instructions from another nurse:

Sanna: Hmm, I sensed a bit of uncertainty coming from her. You know, just "someone showed me to do it like this, and I'm not sure, and now someone else is telling me something different, what am I meant to do now?" you know? I always find situations like that tricky because I can't check if the other nurse really did tell her that, or if she just understood it wrong. You know if she [the nurse] were on duty tonight I would ask her but she's not. Yeah, it's always difficult because I don't want to show my colleague up. (C4/245-265)

What becomes obvious in the above statement is contradiction in teaching care tasks. Since women lack a frame of reference, they are unable to judge which advice to take on board. Hillan (1992) reports that conflicting advice is one factor contributing to an increase in stress. Consequently, the nurse needs to satisfactorily convey the correct information or instruction 'enabling' the woman to acquire or regain self-confidence.

According to Carol, this incident caused frustration for her as she recounted in our final conversation. However, the above statement shows that the blame was thought to be Sanna's. Conveying dissatisfaction with care provision in a state of emotional turmoil or low self-esteem, and more so in a dependent position, proves to be difficult. Doing this in an indirect way, as above, can relieve stress, however attributing blame to other people might cause friction between other staff members. Since there was no opportunity for Sanna to clarify that issue with her colleague it produced tension for her. Hence, the situation remains unsolved causing dissatisfaction for both the woman and the nurse.

There were other situations when the nurses lacked expertise and confidence, and so relied on other professionals such as obstetricians. The following example shows that the nurse caring for Hanna was not in a position to intervene appropriately:

Hanna: It was Saturday when I said well it's not the episiotomy hurting, it's something else like a lump right at the anus and it'd, this was what bothered me and then a doctor came to check the next day. I don't know if you were there.

Irena: No, I wasn't but I've read about it.

Hanna: And he, I suspected a haemorrhoid and he said maybe, but somehow, yes it could be that he said and he prescribed an ointment, which I still apply but I'm not entirely, you know it doesn't hurt anymore when I sit, but I can see the lump is still there and I've to wait and see and maybe it'll get better. Well at least I can sit properly

and it doesn't cause pain anymore. But in the beginning it was very irritating and also because sitting, or not being able to sit properly, or sitting strangely. (H2/911-941)

From the above, the woman remained suspicious as to whether the prescribed intervention was appropriate since it seemed not entirely helpful. Furthermore, it is of interest that the nurse considered this issue not in the range of her competence, but rather as the doctor's responsibility.

As this sore episiotomy was an issue over several days I was interested to hear how Nurse Maja, who was assigned to Hanna during late shifts, perceived the situation and what caring interventions she would suggest:

Irena: What are the possibilities that you offer to women about how they look after the episiotomy?

Maja: Well it's rather difficult as long as the stitch is still in, you shouldn't put cream on, you know? It's good just to rinse it to keep it clean and beside that one can't do much. And with this cream, I wonder how it works, because the lump is so close to the anus. (...)

Irena: Are there other ways of caring for the tear?

Maja: Some ointment or to massage it with almond oil or so, just to do something for the episiotomy.

Irena: Hmm, is this what you usually recommend to women, something they should do perhaps?

Maja: No, I usually don't say that, actually, nobody's ever asked me about that directly and on my own accord, no, but I could mention it in the final talk, yes, what they can do to keep it a bit softer.

Irena: Hmm, well this isn't something that belongs to your repertoire, something that you mention?

Maja: No, no

Irena: What's the reason for that?

Maja: Yes, maybe it is because it's something rather new and ... no, I really don't know why, yes I probably just forget it.

Irena: Yes, hmm, yes, I just was interested to hear if this is part of your routine, just because it came up with her.

Maja: Well I think it would belong in our area and some of us do mention it but I think, it also is in the doctor's domain because they check the episiotomy before discharge and so and well the obstetricians can tell them that – yes.

Irena: Okay.

Maja: Maybe I have my inhibitions there too, because of the issues of sexual intercourse and things in the final talk, I don't know if this is something that belongs to my repertoire because yes, to just mention it by the by, if it comes up, sure, if they ask, but otherwise I believe it's the obstetrician's matter. I don't know the women that well and – I do notice, I feel a bit uncomfortable with that, and I think at the end of the day it's not my business.

Irena: And the women don't ask you about it that often?

Maja: No, so far they have never asked me. I just heard somebody saying that she would regularly mention this and then I thought – I'm not quite sure if I would give this information in addition to everything else. (H3/295-429)

'Enabling' the woman to care for herself in the best possible way appears to be a hidden intention. The above also gives a detailed image of a sensitive issue in postnatal care. What becomes obvious here is that the nurse connects the care of the episiotomy with information about sexuality issues and she distances herself from such accountability. An inner conflict occurs in this statement as to what and how she could respond to the woman's needs. This might well explain why she called for the obstetrician but subsequently doubted the correctness of the intervention. Fichardt *et al.* (1994) conclude from findings in their study that issues such as sexual intercourse and contraception are of importance. However, they argue such "subjects are possibly avoided during education because of their sensitive nature" (Fichardt *et al.*, 1994:19).

On an organisational level, the traditional division of labour between obstetricians and nurses can be seen as a determining factor in the nurses' behaviour. In the unit's guidelines, provision of information about sexuality issues is not explicitly mentioned. It could be understood to be included in the guideline, 'Exchange of information between parents and nursing staff', since the aim of that particular guideline is to ensure that parents receive all the information they need in suitable language in order to feel secure in their new situation. However, in Hanna's case the nursing interventions were inadequate because of the nurse's personal attitude and insecurity.

What also became obvious in the course of my fieldwork was incongruity with certain caring issues. In her statement above, Nurse Maja attributes a different status to health promotion compared to other nurses. When I attended the discharge talk with Flavia, Nurse Jennifer addressed a whole range of issues including partnership, body image, sexuality, contraception and emotional well-being. The contrasting views of those issues gave rise to discussions in team meetings. Since they were not anchored in a guideline it was left to the individual nurse to decide what issues she would address and how she would integrate them into her daily work.

In the final conversation I had with the participating women one aim was to reflect on received care, which was inevitably connected to the nurses' conduct. Liana gave an example of how she perceived the performance of stressed and less experienced nurses:

Irena: How did this work situation affect you?

Liana: In lots of different ways. There were women, I mean nurses, who could cope better with stress and others who coped less well. So, let's say, there was maybe one, who got confused by the whole thing because she had an awful lot on her plate and said yes to something but then just forgot about it. But I didn't blame anyone for that, because I can easily imagine that some things do just get forgotten, if it's not something totally necessary, just something extra. For example to show somebody something or to bring something, things like that. And anyway, if you really did want something, you had to pester them a bit, could you bring me this and then it would be yes, yes, of course, and then it worked out. But for the last two late shifts, there was a nurse who was mega-organised, I felt, and I got so much information from her. (L2/563-596)

Here, Liana rhetorically excuses the nurse and differentiates between important and extra tasks. However, not responding to needs and wishes affects the woman as a person. Women in Bondas-Salonen's study (1998b) experienced absence of care and rather than requesting it they would try to understand why the nurses were not available. As shown above, prioritising needs and insisting on interventions resulted in a little frustration. A further aspect brought out is that Liana characterises experienced and inexperienced nursing staff and notices the effect such behaviour has on her.

Perception of care is also demonstrated in the next two statements, which are taken from Hanna's and Eleonora's data set respectively:

Irena: Looking back on your time on the postnatal unit, I'd be interested to hear from you if your expectations were met.

Hanna: In terms of care from the nurses, I have to say it was very, very positive and also the needs and requests I had, they were definitely met. And in terms of – care of me and also of the baby and things, that you can be with the baby all the time and to give him to them when you like, when you feel like it, yes, they really dealt well with all my needs. I have to say, that was really good, and also, you know, the problems I had with breastfeeding and things, they really paid attention to that. I have to say it was very positive. (H2/318-342)

A similar question to the one above was posed in the final conversation with Eleonora:

Eleonora: Well yes, in general, I've got a very positive impression. I think that's more to do with the staff than with the place or anything else. I found the atmosphere very relaxed – although it was actually one of the more hectic units, but I found it pretty relaxed, I didn't feel like they were in a hurry to get rid of us. Another good thing was

how they protected your privacy, you know with the screen, that impressed me. (...) What I really appreciated was how women were treated as individuals and not as 'Room 300'. (...) I never had the feeling, oh, I better keep quiet otherwise someone'll get mad at me, I never felt like that. And another thing I noticed is that the midwives, no, I mean the student nurses, they really make a big effort to, um, - yes to look after the mothers, to give them the care they need. I really noticed that, and - what was also good, when students weren't sure what to do, you know when a question came up, they went to ask someone and didn't just tell you any old nonsense. (...) That really shows good teamwork, among themselves, that they're allowed to ask. And that gave me something like - yes, a certain confidence. (...) And I also felt safe when they checked my womb and the cut because I thought, if she's not sure, she'll go and ask someone. (E2/686-766)

Both statements reveal individualised care. The aspects Hanna and Eleonora comment on demonstrate the complexity of postnatal care. In the first statement the perspective is taken from the woman's needs, whereas in the second there is a broader stance which takes contextual aspects into consideration. Martell (2003) states that structural and social conditions influence women's perception of their care, and thus affects their recovery.

As with the nurses, I sometimes had the impression that women were tempted to report mainly positive experiences of postnatal care. Despite an invitation to candidly express what it was like for them and to comment on the fact that women were no longer dependent on those nurses, their feedback remained in a positive range. An excellent example in this respect was given by Alicia at the very end of our conversation, after she had reported an incident of unsatisfactory care provision:

Alicia: ... well, if this is all coming across as really critical of the nursing students, that's not what I meant either, it's ... I think they were very perceptive and at the same time it was interesting for me to see the other side. (...) But I do think it was acceptable, you also got a sense of how they were being supervised, and the effort they went to, I'd like to mention that. (A2/1015-1031)

Similar claims were made by other women in this study. On the one hand women were quite clear about what was satisfactory and what was rather unsatisfactory but in general, they were not interested in putting the blame on the nurses. More often, they tried to find an explanation or an excuse for frustrating behaviour.

As expected and demonstrated at several points, women appraised care provision on the basis of their met or unmet needs and according to the level of confidence gained during hospitalisation. This is confirmed by Attree's findings (2001a) that good quality care was related to patients' and relatives' needs. Furthermore, she reports that individualised and patient-focused care "provided humanistically through the

presence of a caring relationship (...) facilitated the development of trust and confidence” (Attree, 2001a:459). As receivers of care, women are in the best position to audit quality care and to feed back their experience to the service providers. However, one could argue that they lack a frame of reference, and so their evaluation is only based on a lay perception of care. On the other hand, nurses’ perception of quality care delivery is also crucial since it contributes to job satisfaction. Their critical comments in the beginning of this section reveal concerns about time dedicated to women but also lack of professional experience and knowledge. Yet women’s reflections on received care is generally encouraging as it displays the multifaceted dimension of care and the respective responses from staff. It is important to note the fact that support during the time on the unit is not only provided by nurses, as we see in the next account. Giovanna gives evidence of how she relied on her partner when there was a critical episode with her baby:

Giovanna: Hmm – well for me it was really good the way it was. It wasn’t anything to do with the care or anything, why I reacted like that. It was simply because, it was to do with me, and you know they couldn’t necessarily have, couldn’t really have helped me directly anyway. I was glad that my husband was there.

Irena: He was there for you, yes.

Giovanna: Yes and I was definitely happy about that. I wouldn’t have wanted to talk about it at any length right afterwards. (G2/404-420)

This statement shows that nurses are not covering every aspect of women’s care needs. Since partners, and other relatives or friends are present frequently the opportunity to receive support from them is very likely. The importance of the social network is highlighted and moreover intimacy allows sharing feelings at another level. This leads to the next section, which is concerned with the involvement of women’s partners within postnatal care delivery.

Involving women’s partners

Transition to fatherhood does not involve a directly embodied experience but it comprises emotional challenges and adjustment to the new situation for every man. As I have noted previously, the presence of partners during birth and the subsequent time on the postnatal unit were pivotal to all women in this study. Partners’ presence and support during childbirth (Bondas-Salonen, 1998a; Tarkka and Paunonen,

1996a) and transition to fatherhood in general are well researched areas (Barclay and Lupton, 1999; Buist *et al.*, 2002; Henwood and Procter, 2003). Yet, little is known about their involvement in in-hospital postnatal care. In this study, some partners spent most of the day at the woman's bedside, others were seen for a limited time and this more often in the evenings. Therefore not all of the participating nurses ever got to know women's partners. In the unit's guidelines, parents are addressed as receivers of care but the father is not mentioned explicitly. Nevertheless I observed that nurses involved partners and taught them childcare. On some occasions, partners were present during the discharge talk. In the subsequent conversations with the participants, fathers/partners often were a topic. In the next example, midwifery student Marika talks about Diana's partner:

Marika: He was here a lot, and when she still wasn't able to do things, I went with him a few times to do nappy changing, that was twice, and once we did the bath together. So she definitely gets good support from him. (...)

Irena: Have you ever seen him helping her with putting the baby to the breast?

Marika: No, I haven't seen that, no. But I can definitely imagine him doing it. (D5/131-150)

In the following account Nurse Noelle reflects on involving Giovanna's partner:

Irena: I noticed that you asked her partner if he'd helped her with latching on and he said, well, how can I help with that?

Noelle: Hmm, yes that's right, I didn't pick up on that. (...) Well, he could check just as much, or help to listen if she's [the baby] swallowing properly or help her and the baby to get really comfortable. Okay – maybe he can't put her [the baby] to the breast, that's another matter, but he could definitely support her, that's true. (...)

Irena: I've observed partners helping with that, they can obviously see that they can get involved.

Noelle: Hmm – yes it's funny, isn't it? I don't really think about involving the father with breastfeeding, but with childcare, for me it's obvious that the father is a part of it and he should be able to do it. (...) Yes, yes, and it was the same for me, that was always my business. (G4/503-578)

From the nurses' points of view and as is evident in the above accounts, the father's support is mainly seen in childcare issues exclusive of breastfeeding, which is considered a woman's task. Since all women in this study were breastfeeding during their hospital stay, nurses generally ignored input on feeding issues from the partner's side. Fathers' contributions to breastfeeding their babies, as Mander (2004) argues, can be seen at different stages: first, at the point of the breastfeeding decision, and later during the practice of breastfeeding. The decision whether or not to

breastfeed the baby had already been made at the time women in this study setting entered the postnatal unit. Nonetheless decision-making in terms of breastfeeding can be seen as an ongoing process, since this way of nurturing the baby can give rise to questions regarding its success and later, about maintaining breastfeeding. Moreover, the practice of breastfeeding involves partners since Storr (2002:234) reasons, 'it takes three to breastfeed' and men's contribution is to "nurture their partners so they can nourish their babies". Revisiting Noelle's statement and taking into account her personal background as a mother of two, it can be seen that she considered breastfeeding entirely as women's responsibility. In contrast to this particular experience, Storr's view (2002) on breastfeeding paints a much wider picture as it considers support as direct, but also as indirect participation, throughout the process. Integration of partners in this caring task at an early stage could be beneficial for successful breastfeeding. Furthermore it could positively influence the bonding process between fathers and babies.

Teaching childcare to fathers or to parents was observed in many situations during my time on the unit. This could be related to the fact that the hospital had developed and successfully implemented relevant strategies in this particular subject area. This compares favourably with Tarkka and Paunonen's study (1996b), where less than 20 per cent of the women confirmed that their partners had received guidance in childcare. Such practice as presented in this study setting is certainly an early step in supporting fathers and familiarising them with the requirements of the baby (Barclay and Lupton, 1999). Buist *et al.* (2002) write about men's adjustment to fatherhood and they suggest that fathers might need specific assistance in anticipating and developing the role they wish to have during birth and postnatally. As a result, fathers' postnatal experiences need to be considered, their teaching needs recognised and their contribution within the setting discussed. This could well support them in gaining control over the situation, thus facilitating their transition process.

As said earlier, teaching childcare to fathers was common place, whereas their engagement in any other tasks seemed rather alien to nurses. Even though I observed that nurses congratulated male partners on their fatherhood, they usually did not engage them in further discussions. Since Hanna's partner was present most of the day, I asked Nurse Maja how she related to him:

Irena: And have you – apart from the fact that he helped a bit with the childcare – have you managed to involve him in the conversation?

Maja: No, but I have to say I haven't really tried, because I asked myself, he always backs away, that's how it seems to me. He's more in the background – yes. (H3/495-505)

Later in our conversation she turns back to this subject:

Maja: Something that I find interesting is when partners always sit at the foot of the bed. Maybe it's because there are still other people around, or something. But I like to see them sitting a bit closer (...) just for the woman's sake, I think, wouldn't she prefer that too, you know? Of course I don't know what else they do, but he always sits at the foot of her bed. (H3/828-843)

The message in these statements is twofold. One can read a distancing behaviour which places the woman's partner in the position of a visitor. Furthermore, Maja's comment on the man's physical distance from his partner leads to assumptions about what behaviour is appropriate within this context. A hospital environment might well silently prescribe a certain conduct which does not promote physical closeness. As discussed in Chapter Five, Liana gave an account of this subject asking herself if behaviour involving physical closeness was acceptable or not. From what I heard in the conversations with Maja this issue was not touched upon, although she makes clear she would support physical closeness.

The presence of fathers and their role during childbirth is a subject in Bondas-Salonen's study (1998a). She describes that "the presence meant communion to the women and in its deepest sense, the creating of families" (Bondas-Salonen, 1998a:784). Yet, this process transcends the event of birth although little evidence is found about partners' presence on the postnatal unit. Hasseler (2002) remarks that women in her study valued their partners' presence during birth highly whereas afterwards it appeared to be of less importance. However, after the emotional high of birth, the presence of fathers is considered crucial in establishing an emotional relationship with the baby (Barclay and Lupton, 1999). One way of being together is being involved in childcare provision, however being together in silence with the baby also contributes to the bonding process. Such times at the beginning of a new family formation are precious since in this study, most women's partners would return to work some time after discharge and the daily routine would take over. However, the possibility of being there and being physically and emotionally close requires an empathetic environment. Men on a postnatal unit can feel out of place or

even excluded if professionals address only women and babies with their caring behaviour, and Bondas-Salonen (1998a) criticises the fact that partners of childbearing women lack a place in the health care culture.

One other occasion, where the partner was frequently around occurred while I was observing Nurse Esther as she was taking care of Kirstin and her baby:

Irena: Did something change in the dynamic with her when her partner was around?

Esther: It's difficult to judge. He's – I found, he definitely wasn't a disruptive factor, sometimes the husbands are, well it can be rather difficult to care for a woman when their partners are still around, and I didn't get that impression at all with him. (...) Something that I sometimes think is dangerous is when a woman is in a pretty bad emotional state, that – then everyone tries to play it down a bit. With her it was that she was already afraid [of breastfeeding] and then he said, yes, yes, we know what you're like, just like that. (K4/241-269)

Bondas-Salonen (1998a) concludes from narratives with women in her study that the presence of partners would maintain an ideal of being a family. This was rated to such an extent that even uncaring or insulting behaviour of the part of partners could be ignored or downplayed. With reference to the above statement, an obvious conclusion could be that the presence of the partner in this situation was rather irritating for the woman and the nursing staff. Taking the whole picture into consideration, his comments on the woman's behaviour appeared to be supportive. One effect was that the woman calmed down as it helped her to put things into perspective and another effect was that the nurse could progress with her caring tasks. This shows how beneficial the presence of partners can be, although either supportive or unsupportive behaviour may not always immediately be obvious.

Diana gives evidence of how she relied on her partner's support at times:

Diana: Well it was just, sometimes you felt like, oh, I really can't call them again for this, you know, or when I called and it took a while until someone came, well, I felt, I knew they also had other women and a lot to do. But then, if it was something important I just called them, I didn't care.

Irena: So you didn't hold back completely.

Diana: No, definitely not, definitely not, but whenever he was here I didn't fetch the nurse, I asked him to help instead. (D2/237-257)

The partner's presence, hence his support, appears important as nurses were unavailable at times. Availability of care has been critically discussed in Chapter Five. Unavoidable involvement on the other hand can be taken as an opportunity to familiarise partners with caring tasks and prepare them for the time at home.

Similarly and on behalf of other women, Hanna responded to a question about support from her partner in the following way:

Irena: And integrating your partner into all the care, or into the whole situation in general?

Hanna: That was good, I think, hmm – well – of course he was there a lot, and the nurses really took that into consideration and wanted him there. I never got the feeling that he, that someone thought he shouldn't be there, it was more like it was a real joy for him. They were pleased that he got so involved and also supported me. You know in the beginning, when you don't feel so good physically and everything still hurts and then to pick your baby up and put it to the breast, you're really happy to have somebody there, who can give you the baby or hold it. Yes, I think that was really good, he was very well integrated. (H2/797-816)

This statement indicates satisfaction with the level of integration in childcare issues by the nurses. Teaching childcare to male partners was considered beneficial in preparation for the time at home and this was an expectation women had expressed in our initial conversation. From Hanna's perspective her partner's presence was welcomed by the nurses and he was supportive towards her. Martell (2003) points to the importance of having a person around in the hospital environment who is familiar to women. As they offer support and encouragement they function as "buffers to the stress of being in the hospital" (Martell, 2003:481). Such physical closeness facilitates growth into the role of a father, not only from the caring viewpoint but also in terms of father-baby bonding. Partners' presence is also convenient for including them in the discharge talk. Liana gives a brief account how this featured in her situation:

Liana: Well, for example with the discharge talk. At that point he just wanted to be with the baby but then she said, well, just bring her along and so the three of us went to the talk, and they really pay attention to that. (L2/528-536)

Attendance of the new family in the discharge talk came naturally, and was a satisfactory experience for this woman. Similarly, in the case of Britta when student nurse Muriel conducted the discharge talk, her partner and the baby were present:

Muriel: I thought it was very good that he had his own questions and particularly in terms of the baby's wryneck, so we could clarify that. I thought it was good that he was there. (...) Partners have different questions. (...) Yes, it was when we, when he asked me about the routine, you know if you could sort of force a routine onto her [the baby], to feed her every four hours for example, and I just said I wouldn't do that because she would get into a routine herself as soon as, hmm the milk, the milk production becomes regular. (B5/229-371)

This example shows what this father's concerns were. As the student nurse remarks "partners have different questions" and such occasions offer an ideal opportunity to respond to those directly. She further reasoned this might prevent arguments between the parents about conflicting ideas. In the following excerpt from Kirstin's data set, she refers to the importance of her partner's presence and his contribution to certain tasks:

Kirstin: I like the fact that the husbands could come when they wanted, that wasn't limited and I thought that was good. Hmm, he had to work, so his level of integration is, well was going to be limited obviously because he's working. But I think, things like feeding, he doesn't need to know about whatever. But I wanted, he wanted to know how to change the nappy and how to bath the baby, which are two things he can obviously do and that was quite good because they've got the room where the fathers could go and when he came I just rang for the nurses, okay, would you mind taking him to change the baby and show him how to do it and hmm, so he learned that and bathing the baby. He wasn't with me the first time, so we gave a bath when we left, the day we left, just before we left the hospital because I wanted to do it again to make sure I was absolutely clear what I was supposed to do and everything else to know about it. You know, it's a little baby and it takes more time. So we did it together and my husband was there. I asked her could we do it when my husband is there and she said, yeah that's fine so we did it when he came and hmm – I think, you know, he – was, he has quite a lot of patience and that's as much as he could be, I think. Maybe for the final talk I should have thought about having him there as well. But I hadn't thought of that and they didn't suggest it.

Irena: They didn't say anything?

Kirstin: It might be a good idea if they did, maybe suggest it, you know, do you want your husband here. Because maybe he's got questions, or worries or concerns.

Irena: Yeah, usually, fathers have questions.

Kirstin: Yeah, absolutely, so that I think would be a good idea. Apart from that, yes they made every effort to integrate him as much as they could. Yeah, and I mean, she was sleeping most of the time. So there wasn't a lot he could do apart from actually ... (K2/1489-1545)

Since Kirstin's mother tongue was English she admitted having some difficulties with understanding all the information provided in the local Swiss German accent. Despite speaking German fluently she recognised a limit to her ability to grasp some information. The presence of her partner would have helped her to translate information where necessary. Furthermore, this statement demonstrates that the system primarily employs an orientation towards the individual, something that has been also commented on by Paavilainen and Astedt-Kurki (1997).

As argued previously, the partners' involvement in childcare issues is largely practised within this setting. While it is of a strong interest to women and their partners it is also on the nurses' agenda. Breastfeeding though, remains within the

women's domain. Since all women in this study were breastfeeding during their stay at the hospital they considered their partners' contribution to nurturing the baby as limited and so did the nurses. In addition to this, it becomes obvious that the partner's integration in the discharge discussion is not an established scheme as one might expect from the guidelines. Two possibilities can be suggested in this respect. Firstly, partners could support women by taking in all the information provided during the discharge talk and by retaining it. Secondly, the focus could be more on the family as a unit (Martell and Imle, 1996), which would be one further step in the move towards a family-oriented care approach. Such a perspective might positively contribute to the event of discharge, which inevitably entails a new beginning as a family.

In brief, maintaining a caring relationship as it is shown in this section is influenced by several factors. It takes diverse paths depending on professional competence and conduct as well as on structural and organisational conditions. It appears that job satisfaction, but also women's satisfaction, with received care is considerably influenced by the quality of such relationships. A wider dimension opens up when integrating women's partners as this opens up the familial view. This inevitably leads to the next section in which the termination of the caring relationships at discharge is discussed, giving way to the new world of the family.

Letting Go

As demonstrated in the preceding sections, in this liminal phase on a postnatal unit opportunities for encounters between women and nurses are limited. As a result, length and intensity of the caring relationship are of varying quality. As women move towards discharge, the termination of the caring relationship becomes an issue. Depending on the established rapport, nurses recognise women's capability, which directs them to inquiries of their lay support network. Support from professionals in the community is an issue of importance which also has to be discussed. The following section considers the prospect of women's lives at home.

The departure from hospital to home can provoke upsetting feelings over loss of relationships. Britta was one woman who described briefly how she felt on the threshold to going home:

Irena: What made you feel more vulnerable, or sensitive?

Britta: Well, all of a sudden, when was it? – in the morning, you know I only went home at four in the afternoon and that morning I thought, okay, you're leaving now, and then, everyone was so nice and I thought, you're not going to see them any more now. I don't know if it was because of that, or – it was like saying good-bye, yeah, that's more how I felt, that's another thing over or finished, I think it was more because of the people there, because I wouldn't see them again, you know all of them were really nice. (B2/726-746)

Although the woman-nurse relationship is of short duration, an account such as the above provides evidence that relatedness occurs, and this can result in feelings of loss when it comes to discharge. This can be intensified by anxieties about being alone with the baby, and by awareness of the responsibilities entailed (Oakley, 1980). Professionals learn how to end a relationship, but how to prepare women to terminate a relationship with their midwives as Walsh (1999) criticises, has not yet been taken on board as an important subject. Transferring this argument from a midwifery model of caring into the setting under study could be seen as inappropriate since the ideal relationship between women and midwives is of a different length and quality. Nevertheless and as Walsh (1999) suggests each relationship needs a satisfying closure. The following part considers ways of achieving this.

Building a bridge

Nurses participating in this study made an attempt to prepare women for the time after discharge. This was done either by preparing them to cope with the most crucial tasks at home, finding out what support they would get from their social network or by referring them to professionals in the community setting.

Nurses allocated to Kirstin talked about her worries regarding her baby. Firstly, Nurse Esther perceived them as follows:

Esther: I thought it was really good that she could say what her problem was so clearly, that she was afraid that she wouldn't manage to latch the baby on properly by the time she went home.

Irena: She was really clear about that, wasn't she?

Esther. Yes, I thought it was great that she could just come out with it like that. I think we need that in nursing, so we know things like that. (K4/183-197)

Similarly, Nurse Bettina recounts an episode with Kirstin:

Bettina: She's already thinking about, what am I going to do at home. You know a lot of people only start thinking about that when they're at home and the baby gets a high temperature. She's already thinking about that. Well that tells me that she's definitely very concerned, hmm – unsure, really insecure, and she, well, she's reassuring herself that she'll know what to do later, at home.

Irena: Hmm.

Bettina: So in that sense, it's a good sign but on the other hand, maybe, she's reading up on it too much. (...) It's the same with pumping at home, what am I going to do if the baby doesn't latch on at home, a lot of her questions are related to "afterwards". (K5/327-358)

Such and similar claims were made by other nurses in this study. However, even though there are some ambivalent comments in the latter statement above, the nurses can be seen to have taken the women's concerns on board. This situation shows that postnatal care provided at the hospital is not restricted to the women's time there and as shown earlier in this chapter, this fact is as much a part of the women's expectations as it is on the nurses' agenda. Yet, the strict boundary of intramural care as the current system defines it, allows few opportunities to expand care provision to the time after discharge. The assessment of how women might cope at home is therefore important and subsequently enables them by alleviating their concerns as far as possible.

Nurses allocated continually to the same women became more aware of their capabilities and they could more easily estimate what support might be adequate for them. Nurse Jennifer gives a brief description of how this was with Flavia:

Jennifer: Yes, because she wasn't sure what to do for a long time and I left it open for her. I said she didn't have to decide right away, she still had time. But when she came along the corridor, I thought it was good. She said, "now it's okay, in the morning there's no way I could have decided, but now it's okay". And she's also talked very clearly about confidence, in terms of breastfeeding, with childcare, that she's feeling confident. There are still certain things she has to work on but I think, I've got a good feeling now. (F4/409-424)

This excerpt illustrates that Flavia and Jennifer were able to establish a rapport throughout the days, during which time confidence could grow. As a result, Flavia's behaviour could be read and interpreted immediately by Nurse Jennifer and it appears that the end of their relationship was not a stressful event. 'Maintaining

belief' the woman will cope well and conveying trust in her capability seems a determining factor in releasing caring responsibility.

Similarly, Nurse Helena had reached a level of relatedness with Carol and so was able to effectively assess her abilities and judge what help would be adequate for her:

Helena: I think she's going to be fine at home. I think she'll manage. From what I've seen of her today, already. (...) Well, I wouldn't say that we should make an appointment with the lactation consultant or inform the parental clinic, no, I don't really think she needs it. But it would definitely be good to explain it and tell her that she can always call them, and I think she, I'd say she would do that, I'm certain of that.

Irena: Yes, you think she would seek help.

Helena: I think she would. (C5/294-335)

A direct reference to professionals in the community is always made in agreement with the women. Parental clinics offer their service on an optional basis and therefore women are not obliged to register. However, nurses thoroughly recommend making use of the service since they believe it to be beneficial for parents. Additionally, this service allows for a low-key admittance, whereas registering with a paediatrician or a general practice at this early stage is considered unnecessary as long as the woman and the child are healthy. Aspects of health promotion, expertise in childcare and breastfeeding, and financial issues support the argument of contacting the parental clinic or the lactation consultant in the first instance.

In Kirstin's situation Nurse Esther considered support by a midwife as an option:

Esther: Yes, I think it would definitely be good to offer her a midwife for when she's at home.

Irena: Hmm, what are the criteria you need before you say that to a woman? It's not a general recommendation, is it?

Esther: Just when I detect uncertainty – if I get a really clear feeling. For a lot of women, when they go home, what's really worrying is the amount of work and not childcare or breastfeeding or anything like that, that's mostly what's worrying them. Or not being able to sleep or being on their own all day. ... But sometimes you really sense that they need support with childcare and breastfeeding or with getting their body back into shape. And what we'd normally do is refer them to the parental clinic in the first instance. I have to say, I don't – well, I don't necessarily think the clinic is better, in general, mostly because they have to go there whereas a midwife would come to their house. (K4/573-605)

Here, it seems that a home visit provided by a midwife would be advantageous for this woman. Esther's considerations in this respect were the apparently persisting breastfeeding difficulties which Kirstin was experiencing, and her fragile physical condition after the caesarean birth. Documented evidence shows that the idea of a

visiting midwife was not followed up. From that, and from discussions I had with nurses on the unit, follow-up home visits by midwives were not a standard recommendation during the postnatal phase, neither were all women in this study aware of such a service. Since costs of a defined number of home visits from a midwife as well as from a lactation consultant can be claimed back from insurance companies, such recommendations might well be of interest to women.

Making use of resources

Women in this study had some general knowledge about available professional support in the community and their interest in approaching such services was obvious. Nevertheless nurses provide basic information concerning the community and respond to women's questions generated by their lack of previous experience with such issues. Besides that, there were questions raised, which were not included in a standard set of information.

In the final conversation I had with the participating women, some key issues materialised whereas others were rather marginal but nevertheless important. Liana talks of an array of interests:

Irena: What did the nurses do to make you feel confident?

Liana: Hmm, one thing that made me feel confident was knowing I could always call them if there was a problem. Just having a phone number and knowing you can turn to them. Or at the discharge talk, I didn't know, you know all the formalities or what you have to do, let's say to see a doctor and to make a phone call first. I simply asked if I needed to make an appointment with the doctor or whatever, and I think information like that is really vital, because you – well, you just have to know. There are a lot of things like that and so afterwards it's good because at the discharge talk we really got everything sorted out. This is for this, that's for that, and then there's also the parental clinic. I just think it's nice when you get it all spelled out for you (...) I think you can't get too much information about things like that, and you can always choose what you want and what you don't want. (L2/890-926)

The information she received during her stay on the postnatal unit made Liana feel confident. In a similar way, Kirstin tells what was important to her:

Kirstin: I had my questions ready, what I wanted to know and I got that information so I was happy. It wasn't like I came out with big holes thinking oh, I don't understand them at all. It wasn't like that at all. And I had to know what to do if you've a problem, that's the most important thing, the parental clinic.

Irena: Yeah, have you ever been there?

Kirstin: Yes, I've been there, I went there last Tuesday and I was supposed to go tomorrow and I can't get there, because I can't get the pram down because this hurts so much. I'll ring again and make an appointment maybe next Tuesday. But we went there and hmm, brilliant, really brilliant, really - the nurse, I can't remember her name but it began with an O and she was really, hmm really nice, really good and she just checked the baby and made sure that she was heavy enough, which is my big worry, that she was getting enough milk (K2/436-466)

The parental clinic turned out to be an important source for most women in this study. They consulted the nurses there either to discuss problems over the phone or to pay them a visit in order to have the baby weighed. A few women contacted the postnatal unit as Hanna explains:

Irena: You said before that you phoned the nurse on the postnatal unit. Did you also contact other advice centres?

Hanna: Yes, well the woman [nurse on the postnatal unit], I didn't know her, who gave me advice on the phone, she also said that another thing she would recommend was to go to the parental clinic, you know, to show them my breasts and so on, and then we went there. That was Thursday night when he was vomiting, really vomiting a lot and then we went to the parental clinic on Friday, to have his weight checked as well. (H2/823-841)

This comment demonstrates how relatedness to the postnatal unit helped Hanna to access support easily. An important aspect here is also the time of the day support was needed. Whereas the parental clinic operates on restricted opening hours the postnatal unit is serviced around the clock. Such aspects might well influence the resources women draw on.

Britta was offered an option of contacting the midwife at her obstetrician's practice but instead she decided to see the nurse at the parental clinic:

Irena: You mentioned before that you went to the parental clinic once.

Britta: I only went there because I was curious about how heavy she was – but otherwise, my partner helps. You know when he comes home in the evening, he goes out with her if she's crying but apart from that I haven't really needed any help.

Irena: Yes and you also said there's a midwife in your obstetrician's practice, have you ever consulted her?

Britta: No - somehow the breastfeeding's gone well and so I didn't want to have somebody else in my home. (B2/857-878)

Such a claim could lead to the assumption that Britta did not feel comfortable with a home visit or, as discussed above, that this service was not sufficiently known by women. Since postnatal care in hospitals is mainly provided by nurses, and midwives tend to be employed in settings which provide antenatal or perinatal care, it could well be that midwifery service is not perceived to be within the range of postnatal

care. However, little is known about women's perception of such professional support within the socio-cultural context of this study.

The participating women's perceptions were largely that partners were the most valued support persons within their social network. Almost all of the women's partners were available for help and some had taken days or even a week off in order to spend time together, and to share the duty and the experience of the first days as a new family at home.

Liana's quote is an example as she explains how it was for her to have help from her partner as well as her sister:

Irena: Well, your partner stayed at home for the first few days and your sister was here as well.

Liana: Yes exactly and of course that was really nice. He took Tuesday to Thursday off, then on Friday he went to work and then it was the weekend. That did good, it was like being on holiday, everyone together. (L2/112-121)

To transfer from hospital to home was experienced as a crucial step in the transition to being a family. The time and space shared together proved to be of vital importance for many women and their partners as they got to know themselves as a family in their own environment.

Another source of support is women's mothers. Kirstin had her mother staying with her for some days after she got home:

Irena: That was a great help for you?

Kirstin: Fantastic, I mean my husband is also brilliant, I mean he's doing the shopping and cooking – and cleaning and he's really brilliant, that's really good. But it was just nice to have my mother here, so you know.

Irena: Of course, and it's good to talk to your mother about all these things.

Kirstin: Hmm, hmm – it was, it was really good and she was really helpful. (...) My mother was very, very relaxed you know. (K2/161-184)

A support network, as is made explicit in the above statements, is not necessarily the norm, either for women in this study or for women in the broader socio-cultural context. Women in this study sought help from their mothers depending on their relationship and on geographical accessibility, but this was also influenced by their desire to manage independently as a family.

As mentioned earlier, Carol could not rely on her partner's help as she explains below:

Irena: How confident did you feel at the time of discharge?

Carol: Well, in terms of the baby, it was good. I was still a bit tired, somehow exhausted and you know I couldn't expect a lot of help from my partner but it was alright. (C2/1724-1733)

Despite the tension in her relationship Carol comments that coping with the responsibility at home does not seem to worry her. However, as she moved to her mother's house some days after discharge she got support from her. Carol, as she said later in our conversation, felt very confident in her role as a mother, she said 'I feel I've always been a mother' (C2/1737-1739).

In this section, I have tried to set out both the significance of, and the limits to attempts to use resources. The above statements about relying on resources show clearly two perspectives according to which women are dependent, this being support and change. There are those who appreciate and benefit from resources and those who decide to cope on their own. The consequence is that there is no convincing way in which to clearly demonstrate how postnatal care could or should be attained. However, women also refer to being guided by a kind of inner self as Liana expressed it:

Irena: How was it for you when you went home?

Liana: Hmm, I just feel that if you listen to yourself, you know what to do. (...) I listened very carefully to myself and did what seemed logical to me. (L2/824-853)

Such an inner voice could well be seen as evidence of growing confidence, which facilitates growing into motherhood and the responsibilities that come with it.

It has been shown that discharge causes some anxiety since women in this study realise the loss of a relationship and structural support, but also because of their unfamiliarity with what comes afterwards. Building a bridge between the two worlds seems pivotal in caring for these first-time mothers as it helps them to strengthen confidence in their coping abilities. There is a variety of resources available to women which need to be negotiated. However, it is without doubt that these resources can be helpful to women in successfully transiting from hospital to home, and can support them in this transition process.

Summary

Women had expectations of their time on the postnatal unit and beyond. This time-limited perspective underlines the notion of a liminal phase in which competences are acquired to prepare women for their caring responsibilities at home. In this study, professional guidance and support with childcare and breastfeeding were at the heart of women's expectations, and emotional support and rest were also considered pivotal. There was an air of uncertainty for those women who were not yet in touch with the reality of caring for their babies on their own. In this respect, professional expertise and trustful behaviour emerged as assets since women had envisaged that they would be relinquished to the care of professionals. These expectations inevitably influence how care is perceived by women while they are on the postnatal unit.

The relationship between women and nurses was very important to nurses and also to women although not in the same strong sense. There were many factors influencing this relationship of which competence, confidence and available time were prominent. Structural conditions appeared to have an effect on the way nurses could engage in establishing and maintaining a relationship. These factors inevitably influenced provision of care. Although nurses were aiming at providing secure care they associated unsatisfactory results with professional incompetence, insecurity and unfavourable working conditions. Nurses believed that a continuous allocation had a beneficial effect on care by facilitating a women-centred approach but it also had a positive effect on nurses' job satisfaction. Women on the other hand preferred a continuous allocation but they also referenced consistency in care provision since inconsistency caused disruption and resulted in depletion of quality care.

Women appreciated the presence of their partners and their support. In this respect the family as a unit is brought into perspective. However, the focus of care in this setting remains on women and babies, although nurses involved and taught partners childcare whenever required. Inclusion of partners in discharge talks appeared to occur rather by chance, as did involving them in discussions about other issues. From

that viewpoint and as already conveyed in Chapter Five, the familial view remains in the background in favour of a women-centred care approach.

The establishment of a connection to the time afterwards was inherent in the day-to-day caring process and this can well be seen as preparation for the termination of the caring relationship. Although there were no obvious strategies in terminating the relationship with women, the caring actions pointed towards the future. Questions related to childcare and self-care for the immediate time at home were clarified. This appeared to help women to envisage their life with a baby at home. Furthermore, nurses ensured whether and to what extent women could draw on a support network. However, there was strong emphasis on information about possibilities of professional support in the community and how to contact those. Women were convincingly advised to seek help from such services. Although discharge causes uncertainty and anxiety it appeared that women in this study were able to maintain their confidence and to establish a support network which helped them to cope with their responsibilities at home.

CHAPTER SEVEN

REFLECTION AND CONCLUDING DISCUSSION

Introduction

In this ethnographic inquiry I aimed to reconstruct the postnatal journeys of the women who participated in this study, the caring relationship with nurses and the care they received. Such a reconstruction represents women's lives and experiences in the early postnatal phase, and the professional and human behaviour within this setting. It is also important to note that an interpretation from my perspective as a woman, a researcher and a nurse is inevitably subjective. Nevertheless, what this representation can do is to highlight the complexity of postnatal care, to gain a deeper understanding of cultural and institutional influences and to make a contribution to the body of nursing knowledge. This concluding chapter is devoted to discussing the main findings of the study, reflecting critically on its meaning for further development, and taking a reflexive stance on the research process.

To reiterate, the data for the present study were obtained through observations, conversations with women before and after birth, conversations with nurses allocated to those women and documentation material. However and as explained in Chapter Three, the quotations included draw mainly on the conversations I had with the participants and the written material whereas observational data are woven into the text. The setting where this study took place was a postnatal unit in a General Hospital in Switzerland. As outlined in Chapter Four, postnatal care in this setting is provided by nurses and the unit is geographically separated from the labour unit. A further important detail of postnatal care is that women stay in hospital for up to five days after a vaginal birth or longer in cases of caesarean births or health problems.

Care on the postnatal unit is intended to be women-centred and continuous patient allocation is the type of care management. The hospital's aim is to provide the best possible care for new mothers and their babies and to prepare them for their time at home. The Clinic of Obstetrics was awarded the 'Baby-Friendly Hospital Initiative' in 1995 (WHO/UNICEF, 1991). This background information has to be taken into account to gain fuller understanding of the following discussion of the results presented in Chapters Five and Six. However and to complement the reflexive account in Chapter Three, I will first present reflexive notes of the journey this research took me on and the experiences I have had during this research process.

Reflexive Notes

Before embarking on this journey, I was not aware that using myself as a research instrument would entail the changes, ambivalences, contradictions and challenges that have arisen. However, reflexivity throughout the process of this research facilitated the awareness of my position within the subject and the field. Since I started this research, the field of health policy has changed and so have I. Another important change was in interpreting data as it is likely that meaning changes in the flux of things. Cohen (1992) postulates that ethnographic interpretations are temporary since experience is accumulated, hence is subjected to continuous revision.

Reflexivity ought to conceptualise who I am and what characterises the immersion of myself as a researcher in this subject and in the setting (Aamodt, 1991). In that sense reflexivity is ubiquitous and as Hertz (1997:viii) argues, "it permeates every aspect of the research process, challenging us to be more fully conscious of the ideology, culture, and politics of those we study and those we select as our audience". However, Coffey (1999:132) advises caution with a reflexive account since the "boundaries between self-indulgence and reflexivity are fragile and blurred". Nevertheless, I will now present my account, which will ultimately always remain imperfect.

A personal account of my experiences associated with childbirth was presented in Chapter Four. Even if this account seems idealistic, it was realistic at the time it occurred and informed my initial understanding of perinatal and postnatal care. Although I later learned that in-hospital postnatal care was the norm, I never practised in such settings apart from a short period during my early nursing education. Even during that period, as mentioned in Chapter Three, my understanding of that subject remained distant and rather theoretical as I was always in a marginalised position in this particular setting. Therefore I never considered myself an expert in that field of nursing, although my background as a nurse, a former nurse teacher and a Clinical Nurse Specialist imposes certain preconceptions on me of how care should be carried out. However, my perception of postnatal care for first-time mothers initiated an interest in scrutinising provision of care in relation to women's experiences of becoming a mother for the first time and in what ways changes in practice might be desirable and necessary.

At the beginning of the research period and as noted in Chapter Three, I was partly aware of the limitations and the challenges of an ethnographic inquiry, but chose such a design for two reasons. Firstly, it allowed me to be close to the day-to-day practice and to the participants. Secondly, I was then able to produce data material near to the multifaceted realities of that setting. However, I learned that looking through my eyes (Kondo, 1990), I constructed my own understanding of first-time mothers' experiences, their in-hospital postnatal care and the circumstances. This poses considerable problems of generalising from the particular results and requires caution in drawing conclusions and recommendations. The reflexive account presented here covers the problem of representation and legitimation. What is important in research is not only the way in which data and arguments are revealed. One must also examine how interpretations of those experiences in the field are constructed, and then question how those interpretations came about (Hertz, 1997).

A description of recruiting participants is given in Chapter Three. This process caused minor difficulties. However, babies do not always arrive at the expected time therefore the distribution of the participating women on the unit was uneven. There were two occasions when more than one woman was on the unit at the same time. This resulted in a reduction of the possibilities of observing those women for three

days. I will now focus on the encounters with participants and my experiences in the field, which constantly prompted me to reassess both my perception and my conduct as a researcher. I found myself taking in but not taking on experiences, being close to but also remaining distant to the participants. I could relate to and engage in some issues from the perspective of a woman and a nurse. This constant need to locate myself inevitably characterised the relationship I had with the participants. However, engaging with their experiences was crucial to identify, interpret and analyse the phenomena under study.

On my first encounters with women when I described my role, I realised that they were locating me within their range of experiences as a woman becoming a mother. As I could not share such experiences and since the role of a researcher within nursing was unfamiliar to those women, they were placing me in the role of a nurse. Even though this was accurate to some extent, I became aware of some rather upsetting feelings as I felt excluded from their unique experiences of becoming a mother. Yet later, when I observed women in the postnatal unit I became more involved in the everyday caring process but at the same time more distant to my feelings. This helped me to stay in my role as an ethnographic researcher.

Importantly, throughout the collection of research data, I was aware of the uncertainty and vulnerability of participants during periods of observation and maintained sensitivity towards their personal attitudes and intimacy. This of course sometimes meant a need to withdraw, to leave the room when I felt my presence was inappropriate. In this sense, I exercised common sense and moral responsibility in learning about women and their experiences. However, in our final conversations I felt comfortable in raising sensitive issues, which originated from the observations. The women's responses to these were very open especially in relation to their experiences. On the other hand when referring to specific caring issues and nurses' competence, women said that the care they had received was satisfactory although they expressed certain queries and reported some rather upsetting episodes in their care. I had the impression that they were reluctant and rarely discredited nurses. In that respect an anonymous inquiry might well have produced a different outcome. Nevertheless and according to some women's feedback, reflecting on their expectations and experiences initiated further reflection and helped them to clarify

ideas, to answer questions and to move on in their process of coping with their experiences. Several women expressed gratitude for the opportunity of participating in this study since it enhanced their understanding of the transition process.

Time in the field and working with the participating nurses was a satisfying and inspiring experience. Such collaboration gave rise to many discussions about nursing research and issues of postnatal care. Involvement in such conversations helped me to become closer to the participating and non-participating staff members. Such contacts however, made it also possible for trust to develop, which I considered essential for producing ethnographic data. Despite this openness, the relationship remained relatively formal as I was conscious that I had to avoid any conflict between my position as a researcher and the ability to interact freely with the staff. Precautionary measures were necessary when I was with students. My background as a nurse teacher interfered with my current status as a researcher and I had to be consciously aware of my research eye. On the other hand, the students tended to see me as an expert or supervisor and approached me with questions or asked for confirmation. Other staff members to whom I was a stranger were more neutral in this respect and refrained largely from such transference or involvement in caring issues. Nurses whom I knew from before related to me as a colleague, which was reassuring but also involved the risk of engaging in informal conversations. There were moments when I believed that nurses did or said something to please me or positively influence the outcome of this study. Trust to me occurred when the participating nurses shared their experiences and their caring behaviour with me. I became aware that sharing such experiences made nurses vulnerable as they were disclosing their competences, abilities and beliefs to me as an observer and stranger. Respect and caution were therefore essential to maintain trustful relations.

A constant challenge was presented because I could not take things for granted. It involved following the nurses when they went into the women's rooms as I could not depend on them reminding me to come with them, although they made efforts to do justice to that. Another aspect is that when things seemed clear to me, I sometimes refrained from asking why something was done in the way it was or how they perceived a situation. In this respect, I realised that observation had limits as it led to the assumption that if two people see the same thing it automatically means the same

to both parties. Such situations were usually discovered when I transcribed the obtained data, which prompted more caution in subsequent encounters.

During my fieldwork, I also became aware that my design presented several limitations. I sensed tensions between professional groups, mainly midwives and nurses, and obedience towards medical personnel. My study would have benefited from including the views of midwives and obstetricians especially on aspects of collaboration. Moreover, since the focus was on postnatal care for first-time mothers, I had not considered integrating partners' views on that subject. The one occasion when a woman's partner was present showed me the worth of his contribution as it enriched the data and hence my understanding of the couple's perception of received care. From that and other certain situations on the unit, I learned that changes in direction to a family-centred care approach would necessitate involving partners' perspective. Furthermore the uniformity of the sample provides a rather limited view of women's experiences. The purposive sampling strategy focused on the characteristics mentioned in Chapter Three but did not involve any criteria in respect of the women's social background. Women with a healthcare background are well represented in this study. It also appeared that most participants were fairly affluent, which meant that the population of the geographical area in which the study took place was not evenly represented. Those characteristics inevitably influence the outcome of this study.

When the labour-intensive fieldwork had ended, I missed the busyness of the postnatal unit and the social intercourse with people. Furthermore, I was left with a massive amount of data and with ambiguous feelings about the day-to-day practice I had observed. It was a concern to me that I would be able to write constructively about something which appeared to be a critique. I was aware that my writing would ultimately offer a reduction and simplification, never capturing and representing the complexity of reality. This seemed to me potentially damaging to the participants and the setting.

The post-fieldwork process was similarly challenging as already mentioned in Chapter Three. My intention was to use a relatively straightforward analysing method, which was Colaizzi's (1978) phenomenological method of analysis. I found

it extremely difficult to make sense of my data, to integrate the multiple perspectives of the participants and to interweave contextual information. My attempt to do so eventually failed as I became aware that my data contained more than this method would allow to process, and as a result, contextual and cultural information would be lost. Nonetheless, the process of analysing was located within the construction of social reality (Berger and Luckmann, 1967; Crotty, 1998). This explicitly brought my assumptions and values into play and produced outcomes based on my theoretical understanding of the subject under study. When I finally started to write I found the linearity of a written thesis problematic when trying to interweave theories and empirical findings. However, writing up the research was rewarding as I was able to make sense of the data.

I have remained in a state of liminality as I have written up this research and indeed, I continue to make sense of my data. This highlights a certain degree of uncertainty about my interpretation but it also reflects my 'post-fieldwork' attitude that "there is no end to this process" (Cohen 1992:343). However, I arrived at the conclusion that I do not know the women as the mothers they are now, how they are coping with their lives now and how the postnatal unit is today. What I can be certain of is that changes have occurred. Nevertheless the thesis has come full circle and I am grateful for the experiences I have had throughout this process as they have changed my perception and enriched my understanding of first-time mothers' experiences and of postnatal care provision.

In-hospital Postnatal Care for First-time Mothers

As I outlined in Chapter Two, the postnatal setting provides a space and a timeframe which delineate liminality. This liminality has identifiable boundaries in which early transition to motherhood takes place. The 'betwixt and between' state as well as being marginalised from their own home places women in an exceptional position. In this section I discuss what the participating women expected during their stay on the postnatal unit and how they perceived their status within that setting. Once more, I

highlight the organisation of care and how this affected women's experiences of being cared for while they were on the postnatal care unit.

Women's expectations of postnatal care

The participating women believed that hospital service offered what was best for their birth and postnatal care, although some had considered alternative services. Unfamiliarity with the experience of becoming and being a mother, fear of birth complications but also faith in technical and professional expertise were all factors which supported their decision. Women in this study optimistically emphasised their need to learn about childcare and breastfeeding while on the postnatal unit and to prepare for the time afterwards. In that respect they expected to be able to depend on the professionals' expertise and care in order to become skilled and confident enough to take care of their babies independently after discharge. Such desire for practical care complies with the lay perception of nursing care as well as with the popular notion that the baby deserves maximum attention.

All the women appreciated that this postnatal setting offered a continuous rooming-in approach. Some of them anticipated that they would be tired and therefore need time to recuperate. Thus, to recover sufficiently from the strain of childbearing, women in this study expected nurses to respond with flexibility to their needs and to take care of their babies at times.

Participating women's rather weak indications of their self-care needs led to the conclusion that they felt that they would be able to cope sufficiently with their new experiences. What was remarkable was the degree of trust women said they had in professionals. Carol stated: "The most important thing is really that you can trust everybody". Trust in this sense was multifaceted as other women believed they would benefit from professional experience and personal expertise. However, this was again more in terms of childcare issues since ideas about what they needed for themselves were rather unclear. Women did not specifically relate to the significance of a professional relationship. However and as Giovanna (p179) stated, there was awareness that care would depend on the particular nurse and that the institutional

structure influenced care and hence their well-being while on the unit. In terms of emotional care, professional support was well recognised as illustrated in Chapter Six by Alicia. She expressed it as: “you know, like being carried along a bit”. There was also an expectation of their partners to be there for them to help in this area. As Flavia said: “I would prefer to discuss things with my partner”. Additionally, women wished their partners to become involved with childcare, which implies their wish for their partners to contribute to the familial responsibility.

My analysis of the data suggests that women’s expectations pre-birth are mainly connected with the realm of practical care. However, there were subtle indications that interpersonal aspects were important to them too, as they felt that such a union comforts and enables them to take on the role of a mother and to grow into a family successfully. Another aspect in that respect is uncertainty but also that the time on the unit characterises liminality for childbearing women in two ways: between two places, hospital and home and between two selves, woman and mother. It therefore signifies a strategic use of space. This space is constructed dualistically by service providers and service users and influences women’s experiences in this setting.

Women as patients in the postnatal care setting

On the surface, a postnatal care setting is designed to provide postnatal care to secure mother and baby’s well-being. This is in the best sense to help women to make a successful transition to motherhood, to recover from birth and to learn self-care and childcare. Below the surface however, such a setting functions through a set of regulations and norms with which lay people comply. Examples such as Liana’s (p133) demonstrate how women are inclined to adapt to the routines such an environment stipulates, as they carefully watch nurses’ reactions to their intimate behaviour.

As I have illustrated in both data chapters, these women considered themselves to be patients, reflecting general assumptions of people who are inhabiting a hospital unit. The word ‘patient’ dates back to the 14th century and comes from the Latin verb *pati*, meaning “to suffer or endure without complaint” (Onions, 1966:657). It later came to

refer to a person who was suffering or enduring, and was adopted in medical and hospital terminology. The use of the term 'patient' is therefore inevitably connected with illness. Thomson (1986:163) goes as far as to say that the name 'patient' might suggest "stupidity and an inability to interact and take responsibility for one's health". She suggests refraining from imposing a patient role for 'healthy' childbearing women as they adapt to their social role and assume responsibility for the baby. Moreover, it is expected that childbearing women will be able to contribute to decision-making and hence to influence the caring process. While I agree with this principle reality is more complicated. I argue that as early postnatal care takes place in hospitals, such an optimistic view might exceed women's capacity to become involved in all issues. The situation is made more difficult by the fact that professionals are functioning in a familiar environment, are unavailable at certain times and do not always recognise the extent of information necessary for informed decision-making. Professional behaviour and women's need for care denotes a certain degree of dependency, however this does not mean women must give up their autonomy.

Feelings of dependency and a patient-like role were emphasised by women on several occasions. Hanna in particular referred to the process of labour when she said: "With every contraction I was desperate that somebody would talk me through". The availability of professional help influenced greatly the degree of dependency which the women felt. Reflecting on the birth process while on the postnatal unit, women felt they lacked information at times as well as care from the midwives as they were not always available to them during labour. Diana's account (p129) suggests that decisions made by obstetric professionals within medical parameters were not shared decisions as she had no recollection of the reasoning for a caesarean birth. Another situation denoting dependency was when medical personnel were involved. Having to adapt to doctors' routines caused severe distress for Hanna (p167) and resulted in ignoring her and her baby's needs.

Giovanna explicitly mentioned dependency on nurses for breastfeeding: "I really needed help with that, I was helpless, definitely in the beginning". Since this was an entirely new activity for the women, they depended on the nurses' care. Another aspect which caused the women to feel dependent was the baby's need to be fed,

which determined a schedule for the women. Additionally, the workflow of the postnatal unit, the work pressure and nurses' capacity and competence highly influenced how dependent the women felt. Although work organisation was not prominently recognised as a determining factor, the women realised that such conditions were out of their control. Diana for example stated: "They were so stressed, they rushed around all the time, there were so many patients there". In such circumstances, women tended to adapt to the situation without complaining and to excuse nurses for not being available rather than demanding care.

Taking these aspects into consideration, it is clear that women experience dependency on the professionals' competence and care and the routine in this setting. Consequently, they adapt a patient-like behaviour, which can lead them to feel powerless. Likewise there is ample evidence that they are treated as patients. Thus, the outcome of this analysis suggests that there is little awareness of the women's vulnerability and dependency within the field of postnatal care from the respective professionals. This postulates a re-conceptualisation of women's position in postnatal care. However, changes in that respect need to be driven from within professional groups as women could benefit from a more independent status. Having said this, a home environment would allow women to be more in control of the situation and to be better able to determine the flow of things. Simultaneously, this calls into question whether in-hospital postnatal care is still appropriate in the way it is currently structured and organised. Therefore, the next section considers aspects of control and continuity and whether and how these influence women's experiences of postnatal care.

Control and continuity

Time and space for women on the postnatal unit was governed by several factors. One aspect of time was the length of stay on the postnatal unit determined by the well-being of the woman and the baby, their social circumstances and economic factors. Another aspect was time available for recovery, which was largely affected by the routinised nature of the unit. For all the women in this study, the hospital setting did not provide the atmosphere needed for sufficient rest and recuperation

although they did experience time slots when they could withdraw. However, it was possible for some women, for example for Flavia (p160) and Alicia (p137), to create a niche where togetherness with the baby and the partner could be experienced. Such moments did not depend solely on the woman's ability to take control. Some nurses also promoted conditions that supported family time. More often the women's space for quiet times was limited. This was highly influenced by the physical layout of the unit with a maximum of three women and their babies in one room, nurses walking in and out seemingly at will, as well as a frequent flow of visitors. Such circumstances were unsatisfactory and made women consider early discharge. This demonstrates clearly that the intimacy of such a unique experience can not be safeguarded in a public sphere such as a postnatal unit.

Space and fragmentation of care affected the women's comfort and quality of care since the organisational structure imposed a separation of postnatal care from care provision in the labour unit. This separation was not only spatial but also involved the division of professionals responsible in the two settings. Within this hospital culture, women did not question such a fragmented provision of care, possibly because they knew there were no existing alternatives. Nevertheless, in terms of care in coping with birth experience, women missed out on uninterrupted care from the respective professionals. Olin and Faxelid (2003) suggest that such care is best provided by the same professionals who are involved in the experience of labour and birth. However, within this setting, limited availability of midwives and obstetricians complicated this procedure. Arrangements of meetings with such professionals, although officially offered, were scarce. Carol (p128) was the only one to have such a meeting with her obstetrician. Consequently, such a fragmentation of care has a clear disadvantage in respect of supporting the women in coping with the birth experience, hence facilitating transition into motherhood.

Allocation of nurses and the mode of care provision on the postnatal unit characterises the autonomy given to care receiver and care provider. Organisation of care in the broad sense obviously influenced the level of support that the women felt they had received during their time on the postnatal unit. As demonstrated with examples taken from Flavia's (p188) and Carol's accounts (p188/9), women benefited from and appreciated continuous care provision by the constant allocation

of a few nurses. Not all women in this study commented on this but as Kirstin (p190) recounted, discontinuity of the carer's allocation was recognised and this experience was perceived as somewhat distressing. As a consequence, continuity contributed largely to women's well-being, hence satisfaction, whereas discontinuity caused some degree of dissatisfaction with postnatal care. This applies in a similar sense to nurses as continuity in their allocation to women contributed to their job satisfaction.

Women's journeys to motherhood in the early days post-birth are set within a structured environment. Such a unique experience is affected by fragmented care provision as well as the day-to-day practice with its organisational constraints. Consequently, there appears a dissonance of these intertwined processes. In what follows, I discuss in more detail how women experienced postnatal care, how it affected their journey to motherhood and what the nurses' views were on care provision.

First-time Mothers' Experiences of Postnatal Care

As a conceptual framework, Swanson's theory of caring (Swanson, 1991, 1993) is used here to discuss the care provided to first-time mothers within the distinct boundaries of the postnatal unit. The five caring processes which serve as a structure were introduced in Chapter Two. A short summary of the most important point from that chapter will nevertheless be given at the beginning of each section. Although this construct promotes focusing on caring issues, it also has disadvantages in that it cannot go beyond the scope of it. However, as my aim here is to reconstruct the experience of care for first-time mothers in this liminal phase, I will take wider perspectives into consideration where it seems appropriate.

Caring for first-time mothers by 'maintaining belief'

One of the processes of caring is 'maintaining belief', which means that receivers of care have the ability to get through life events or transitions. According to Swanson, there are two levels on which nurses should act. The first of these is the interpersonal

level, where the nurse helps to sustain the mother's or parents' faith in their capacity to cope with their experiences, create a way of accepting outcomes and find a meaningful future. On a deeper level and in order for nursing to remain committed to serving society, nurses must also be able to 'maintain belief' in people's capability and ability to care for themselves.

The birth experience featured predominantly in the early phase on the postnatal unit. However, some women, for example, Hanna (p127), were still trying to make sense of it when they were at home. Therefore, it is important to pay attention to this area throughout the time in hospital, something which challenged women and nurses. As stated in the section 'Impression of Birth' in Chapter Five, sustaining women's belief that they coped well and supporting them in their coping behaviour is pivotal to getting through the transition to motherhood successfully. From the perspective of a subsequent pregnancy and birth, satisfactory coping with the event is crucial. Encouraging women to recount their experiences and listening to them as they tell their stories supports effective coping.

The participating women's individual reactions to their birth experiences varied widely as did their coping behaviour, which called for individual interventions from nurses. Kirstin's situation (p126) demonstrates a misinterpretation of her coping behaviour, which inevitably resulted in inadequate care. Even though nurses occasionally encouraged women to talk about their experiences of birth, a systematic follow-up procedure was not in place. This was also reflected in the care documentation, as it gave little information about women's birth experience, the emotional effect this had on them, their coping behaviour and the interventions. Furthermore, women's partners were not encouraged to talk about their impressions of birth nor were they included in any formal discussions about it with professionals. As mentioned earlier, the fragmented care organisation in this setting, lack of professionals' presence and the clear lack of attention to the subject of birth experience call into question professionals' capacity and competence in assessing and responding to such a momentous experience.

In this liminal phase women were highly sensitive, vulnerable and still exhausted. Their emotional condition could fluctuate and little was needed to disrupt their

equilibrium. The baby's behaviour, the partner's presence or absence as well as interference from other persons caused disturbances. Vulnerability was accentuated when women received contradictory advice from nurses as was shown in Carol's case (p198) when she was taught differing breast massage techniques. 'Maintaining belief' became eminent as she lacked a frame of reference to judge the adequacy of interventions. "A weepy mood" as Britta for example experienced brought forward a state of emotional imbalance as she saw herself confronted with not only the mounting responsibility at home but also with feelings of being lonely or lost. 'Maintaining belief' proved pivotal with the inevitability of discharge. Concurrently with discharge, a number of women experienced the 'baby blues', which intensified feeling low. Throughout my observation on the unit I observed that 'baby blues' symptoms were acknowledged. However, the event of discharge increased feeling low and this was not recognised by the nurses. This raises the question of how to avoid such concurrences and if a hospital setting provides the right environment to enable childbearing women to pass through that early phase of transition to motherhood successfully.

Discharge from hospital marked a turning point for the participating women. Leaving the liminal space of a postnatal care setting made them aware that they were now establishing a family. Eleonora explained: "All of a sudden it dawned on me, you know two of us came into hospital and now three of us are going home, that was strange". This awareness left a few women feeling uncertain but at the same time that there was something to look forward to. A growth in confidence in their ability to care for the baby was demonstrated by all the women throughout their hospital stay. However and as mentioned above, when it came to discharge a decline of women's self-confidence became noticeable. This was prompted by the confrontation with the many issues they would have to cope with at home. As the women still felt they were not back to their full physical strength, uncertainty in terms of the practicalities of childcare, especially breastfeeding, caused a decrease in self-confidence. Being left without professional care was of concern to some of the participating women as Liana for example said: "Now you're going home and there you can't press the buzzer and somebody'll come". To counteract this, nurses addressed women's

practical capabilities and worked towards sustaining the women's beliefs that they would be able to cope with the impending responsibilities.

In almost all circumstances the presence of the women's partners and their involvement in caring issues contributed significantly to the women's well-being. It helped them to maintain their belief that they would be able to cope with the responsibility and their emotions. Sharing joy and worries as well as tasks were important to all the women. In a situation taken from Kirstin's data set (p207), when her partner functioned as a mediator between woman and nurse, it helped her and prompted a better understanding for the nurse.

'Maintaining belief' proves an important caring process on an individual as well as on a familial level. Coping with highly charged emotions and growing into a confident and caring mother for a first baby are intertwined with women's journeys on the unit. The unstructured follow-up procedure of birth experience is unsatisfactory as women are more or less left to deal with it by themselves. Women's experiences of baby blues symptoms in concurrence with the event of discharge are further points of criticism. However, efforts to maintain women's belief in their abilities are obvious in many situations.

Caring for first-time mothers by 'knowing'

'Knowing' is the caring process of informed understanding of events as they have meaning in the life of human beings. 'Knowing' links nurses' beliefs to whatever the care receiver's reality is and what she/he is asking for. One aspect of 'knowing' is professional knowledge, which is required to provide good quality care for first-time mothers. Another aspect is personal knowledge, that is to say the nurse knows the receiver of care well enough to synthesise these two aspects so that caring results in adequate care provision.

Significant to care provision is the knowledge base nurses have and the experience they gain through working with women. As is shown throughout the data chapters and made explicit by Hanna (p177) and Alicia (p177), participating women clearly expected professional expertise in acquiring skills and knowledge for their tasks and

to support them in their transition to motherhood. According to the guidelines mentioned in Chapter Four, there is a set of standard postnatal care interventions. However, individual assessment is required to provide satisfactory care for women. Assessment was an ongoing process throughout participating women's hospital stays. Nurses tended to enquire at each encounter what interventions were best in any particular situation according to women's responses to their experiences. However, lack of professional experience and knowledge but also a busy hospital routine impeded such processes. It appeared that inexperienced staff members tended to make assumptions as student nurse Larissa stated: "Maybe these are just needs that I think she has". According to the guidelines, an assessment interview might be useful to the nursing routine. This would provide nurses with individual information about each woman's situation. Based on such information a more individual caring approach would be possible. Liana was one of a few women who was not assessed in that way and with other women it happened at a fairly late point in their stay on the unit. It was made obvious in Chapter Six with the examples of Anja (p196) and Fabienne (p195), who were overwhelmed with work, that time for a continuous assessment was scarce and the assessment interviews had not taken place. In such situations, care provision was not to the satisfaction of the nurses and the level of care also failed to meet standards set by the unit's policy.

Another source of information is care documentation and it provides nurses with background information about women's situations, their experiences and their physical and emotional well-being. Entries in care documents result from and respond to caring interventions. Two qualities are essential to the development of care plans. Nurses need a sound knowledge base as well as communication skills to communicate adequately with women and to work out what is best for them. In the care documents of the women in this study as described in Chapter Five, section 'Evidence in the care documentation', entries for example about their birth experience were either absent or insufficient. Consequently, nurses taking over care of these women would not have been able to reach a sound understanding of what had been happening in previous days and what stage of coping women had reached in respect of their birth experience. Drawing on that example, inconsistency in caring

for those women became apparent and furthermore, the complexity of care for this group of women was not visibly stated.

Each encounter between women and nurses contributes towards getting to know one another. Some nurses in this study were able to connect easily with women and to conceptualise the course of care based on mutual agreement whereas for others it was more challenging. For several nurses in this study, for example for Jennifer (p187/8), such a caring relationship was pivotal in terms of satisfactory care provision. It was also meaningful to Jennifer on a personal level, hence giving her feelings of job satisfaction. Prerequisites to establishing a relationship are for example personal and professional competence. Some nurses in this study were critical of themselves and their perceived lack of knowledge and skills. In that respect Nurse Leah said: “I realised I can’t offer the things that I want to”. Others, and this applied mainly to participating nursing and midwifery students, were more ignorant as shown in the example of Alicia’s baby (p185/6) with the Guthrie test. Insufficient understanding about what caring for first-time mothers entails, overtaxing responsibility but also lack of a knowledge base and experience were contributing factors. This shows clearly that the professional expertise of nurses in this field is at different levels, which inevitably leads to differing performances.

As illustrated in several places in Chapter Five and Six, nurses such as Leah (p194) and Carla (p139) were required to cope with either little experience and lack of knowledge or in Sanna’s case (p198) with the incompetent teaching of a nurse colleague. Such situations left them with feelings of insufficiency and inadequacy but they also provoked reflection thus leading to situated learning.

It became evident that nurses’ competence was well recognised by the women. Rationales for the women’s critical voices were their personal experiences of received care. The women were also meticulously observing nurses’ actions and reactions and comparing them with those of other nurses. It could be argued that objective criteria were absent. However, as Attree (2001b:67/75) states, care receivers measure quality care on outcome criteria such as “feeling comfort, happy, informed and satisfied” and their progress of “getting better and going home”.

Sensitivity in judging nurses' competence by the effect received care had on them was demonstrated by Alicia (p202) and Hanna (p201).

Insecure behaviour from nurses also resulted in uncertainty for participating women. In a state of high vulnerability nurses' insecurity can easily be transferred to women, hence affect women's confidence and weaken their trust in nursing care. This is well illustrated with the example of Carol (p198) who received contradictory teaching, which left her frustrated.

The caring process 'knowing' requires professional knowledge and experience, and knowledge about women's individual situations. 'Knowing' in the best sense contributes to a women-centred care approach. This inevitably led to satisfaction for women and nurses in this study. Wherever components of knowledge or experience were absent, dissatisfaction became evident and this was perceived by the women as well as by most nurses. In that respect, it can be argued that care provided by midwifery and nursing students and by inexperienced nurses failed to meet the standard of women-centred care in several situations. Such caring behaviour has an effect on women's confidence, hence on their well-being.

Caring for first-time mothers by 'being with'

The caring process 'being with' necessitates emotional presence. Caring almost always involves some actions but Swanson states, the nurse's physical presence is not absolutely vital at all times. However, women need assurance that nurses would be available whenever they need them. This emphasises the importance of the nurses' availability as women perceived nurses' competence by such caring behaviour. 'Being with' is illustrated by a situation when a baby's crying required a nurse to guide parents and to reassure them in their performance. However, the ability to cope with difficult situations with women goes beyond practical engagement and it marks the human part of professional nursing.

Overall, women in this study evaluated received care as satisfactory but there were particular situations where 'being with' was clearly missing. Nurses' availability was restricted because of heavy workloads as Fabienne recounted: "I didn't have a lot of

time – yes – because I had four other women besides her”. Likewise, this was also felt by several women as illustrated in Chapter Six and was explicitly stated by Diana (p207). Limited presence for practical care inevitably leads to a restriction of ‘being there’ on an emotional level. Some women such as Liana linked such behaviour to the degree of professional and personal experience and competence. A contrasting example of ‘being there’ is given by Flavia: “She really had a complete picture somehow, of being a human being, being a mother, being a woman, (...) just so things come full circle”. Such a statement is born out of individualised care and results in expressions of satisfaction from both sides. Mutuality is nourished by trust in each other and empathy. Consequently, taking on the responsibility of care and engaging on an emotional level with women in this liminal phase demands not only a competent nurse, but also environmental conditions which support such a performance. Restricted presence as an effect of work overload as already mentioned above is one of the factors which prevents nurses from performing on the human level. The mode of care organisation, nurses’ competence and how they engage in a caring relationship are further factors supporting or impeding ‘being with’.

To reiterate, nurses in this study considered ‘being with’ as an important caring process and it was vital for their satisfaction. They often considered ‘being with’ to be connected to a continuous allocation to the same woman. However, the analysis revealed that despite discontinuous allocation, as shown in Kirstin’s situation (p190), ‘being with’ was still experienced. This suggests that ‘being with’ takes place when nurse and woman have established a rapport and when nurses show responsibility for their caring behaviour.

In this liminal phase, women are very vulnerable and they have to learn a great deal at the same time. ‘Being with’ as shown in Chapter Five became central when women were breastfeeding. Giovanna (p154) confirmed the benefit of having the nurse in the background although she was not involved practically. ‘Being with’ was also important when women and/or their partners were caring for their babies as Marco stated: “She spent so much time with me and showed me how to do it and watched and waited till I was done with it”. In the transition to motherhood confidence can be low as everything is entirely new. Praising and reassuring women as Nurse Esther did was done with the aim of strengthening the woman’s confidence

and feeling “good as a mother” and Kirstin confirms: “They were always so positive”.

‘Being with’ women’s partners was not evident throughout my observation. In situations when partners were present, as it was with Hanna’s partner, professionals set up patterns of interaction which did not involve the partner. Partnership issues, as shown with the example of Carol (p147), were not touched upon. This shows that women and babies remain the centre of attention in postnatal care. Whilst this corresponds with the aims of this setting, the social context is not sufficiently taken into consideration. As already discussed earlier in this chapter, this indicates that a family-centred care approach is not on the nurses’ agenda.

To sum up, ‘being with’ is considered the core of caring in Swanson’s understanding and it featured in many situations in this study. This caring process was considered important to nurses. They referred to constraining conditions and the effect it had on their satisfaction with provided care. On the other hand, the women experienced ‘being with’ and whenever they felt nurses responded to their needs adequately they expressed satisfaction. However, they also perceived a lack of ‘being there’, which was linked to organisational conditions as well as to professional competence.

Caring for first-time mothers by ‘doing for’

‘Doing for’ is the therapeutic action whereby the nurse does for the receiver what they would do for themselves if it were possible. ‘Doing for’ in a competent and skilful way includes comforting the other, anticipating their needs, protecting them from harm and preserving their dignity. As much as it entails practical activities, ‘doing for’ also involves communicative actions, which address the psychosocial realm of care.

In the postnatal care setting under observation here, professional care on a practical level featured prominently. This is distinct from what women can expect after discharge since no professional support is arranged. The first priority on the nurses’ agenda in this postnatal care setting was to ensure that women gained full responsibility for caring for themselves and their babies. For women in this study

childcare issues and breastfeeding were a priority and this largely corresponds with what they had anticipated. Such an agenda inevitably determines nursing activities but 'doing for' women featured also in calling a doctor in case of health problems or directing visitors.

As was made obvious, self-care issues were more difficult for women to anticipate but their needs materialised more clearly during their time in postnatal care. In general, the amount of physical care for participating women after a vaginal birth was rather less, whereas women after a caesarean birth required considerably more attendance. In that respect, the physical aftermath of birth necessitated interventions mainly within the first days, which were dealt with in a prescribed routine. Beside that, an individual and ongoing assessment was vital as conditions could change rapidly, and standardised care would not suffice, thus requiring adjustments in interventions. Alicia's example shows that individualised care failed: "I often said I'm in quite a lot of pain – like that - yes and this was just – oh yes, everybody's in pain". The response to her pain was insufficient and it turned out to be the result of lack of communication and inadequate assessment. As a consequence, the nature of care provided remained on a standard level and did not meet this woman's needs.

'Doing for' was eminent in many situations when women felt exhausted. The emotional and physical strains of birth and labour resulted in tiredness and featured intensely with almost all the women. Eleonora (p138), Liana (p155) and Kristin (p149) for example demanded time to rest and recuperate. However, the daily routine with a new baby including breastfeeding on demand allowed little time for the women to rest during the day. Additionally, the applied rooming-in policy although adapted to partial rooming-in practice in several situations, affected women's sleep at night. Nurses involved in caring for those women were aware of the need for respite. They offered help with childcare and on occasion supported women to find time for a nap while they looked after the baby. Despite attempts to ease the burden and to support quiet times, recuperation to the satisfaction of most women was not possible within the routinised structure of the postnatal care setting as discussed earlier in this chapter. However, a gradual increase in physical strength during their stay on the unit was the norm with women in this study. Subsequently they gained full capacity for their caring tasks.

The amount of work involved in caring for a baby surprised and overwhelmed all participating women. Preparation through childcare classes did not seem very helpful as Flavia's example demonstrates. She stated: "Well, I'd the feeling in these courses, everything was – somehow it didn't touch me". Women in this study who had attended antenatal classes benefited from them for the birth process but they did not feel prepared for the practical work caring for their babies. Numerous examples illustrate the extent to which women needed support in childcare issues from nurses. Whereas Liana (p148) keenly took on the responsibility of childcare, Kirstin (p149) relied on the nurses' care as she still disinclined to push herself. Over the days, women were gradually growing into the responsibilities of childcare but at their individual and different paces. Taking on the responsibility of childcare thus depended largely on women's physical and emotional well-being, on the degree of self-confidence they had but also on previous experiences. This in turn determined the extent of their dependency on nurses' care interventions.

Within the caring process 'doing for', teaching and guiding women and their partners in childcare was an issue. In general, nurses showed a sensitive attitude towards this issue as they assessed the individual needs of parents, pacing the flow and repetition of information or instructions on demand. However there was a notion of routine as Alicia made explicit in the following statement: "If there were too many regulations, then I often thought, well yes, I'll do it my way". In general however, decisions tended to be made in agreement with each other.

Caring for a newborn child also included a close examination of the baby in line with routine. Additionally, it was of central importance to inform and reassure women about their babies' well-being. As illustrated by Eleonora (p135), herself a nurse, explanations about her baby's condition were insufficient since her medical knowledge was taken for granted by the nurses. This and a few other examples demonstrated that communicating such issues lacked firm explanations either because of misconceptions or lack of competence of nurses. However, to a considerable extent, women appreciated the support they received in childcare issues.

While most women in this study could draw on at least some experience with childcare, breastfeeding on the other hand was a new experience and had to be

learned by all the women and babies. Initiation of breastfeeding took place in the labour unit immediately after birth, which applied to all women. However, the fragmentation of care proved difficult as two professional groups were involved in this activity. At first, midwives were responsible for the initiation of breastfeeding whereas later, on the postnatal unit, the nurses took over. It became evident from the women's accounts that different information was given and incorrect latching-on was performed in the labour unit but also later in the postnatal unit. Such inconsistency upsets women since breastfeeding is a highly vulnerable issue because of its intimate and emotional nature.

Teaching and supporting women in breastfeeding issues appeared to be time intensive and time consuming for nurses. However, involving women's partners in those activities was not considered despite some interest. Some women and babies learned it quickly whereas others were more challenged. As exemplified by Alicia: "It's at the heart of everything. It's really just something with a couple of tricks to it, and, um, I feel it really helps you a lot and has taken me forward". However, some of the women's accounts, especially Diana's (p152) revealed that neither the initiation of breastfeeding nor a systematic and careful introduction to breastfeeding had taken place. Since women were keen to breastfeed and did not always like to be dependent on nurses, Alicia (p151) for example would put the baby to the breast without assistance, and without a full comprehension of the issues involved. In many situations, and Giovanna (p154) for example stated this clearly, the presence of a nurse was required to assist with practical help to latch on and find a good position. However, some nurses were not as competent as others in this caring activity as they lacked knowledge and experience. In such situations, nurses could draw on the support from the lactation consultants on the unit or supervision from an experienced nurse, which was always beneficial for women and staff members. In spite of some unsatisfying experiences, women's responses to how they were taught breastfeeding were largely satisfactory as they perceived it as compassionate and consistent. At the time of discharge, all women in this study except one were exclusively breastfeeding their babies. Consequently, women felt well supported with breastfeeding, which led to a positive evaluation of this important activity of being a mother.

In general, women in this study confirmed that they had received good care. Diana, for example, approved of the nurse as very competent: “Yes just to explain things to me over and over again helped, not only about breastfeeding, apart from that as well”. However, it appeared that women preferred to evaluate received care positively. Again here Alicia rather reluctantly questioned the competence of a student nurse by saying: “Well, if this is all coming across as really critical of the nursing students, that’s not what I meant either”. She was cautious not to discredit nursing staff preferring to maintain a positive attitude towards caring behaviour.

‘Doing for’ appeared to be an essential caring process. The practical part of caring for women and their babies was aiming at gaining confidence in order to attain full responsibility for their self-care and childcare. Nurses’ assistance with childcare was important so that women would have time to rest and recuperate. However, this was not always to the satisfaction of the women as other factors disrupted quiet times. While caring for the baby and teaching childcare to parents were accentuated, women received less attendance concerning their self-care. Assistance with breastfeeding appeared to be vital to establish and maintain successful breastfeeding. However there were inconsistencies in terms of initiation of breastfeeding as well as competent support throughout the women’s stays on the unit. Nevertheless, women confirmed that they had received good care and that their expectations were met.

Caring for first-time mothers by ‘enabling’

The caring process ‘enabling’ is to ensure women’s long-term well-being and to facilitate women’s transition. Within this caring process, coaching, informing and explaining are the interventions towards ‘enabling’ women to perform self and childcare satisfactorily. This is crucial since women remain in this postnatal care setting for only a short period and are left without any officially provided professional help at home.

Nursing activities were aiming at ‘enabling’ the women to take on the responsibilities to care for the babies and themselves. There were numerous accounts in which the women stated that they felt well prepared for their responsibilities at

home. Additionally, most of the participating women confirmed that they had obtained sufficient information and were able to contribute to decisions concerning self-care and childcare or to decide of their own accord what was important to them. However, there were situations when women realised a lack of information as was the case with Liana: “The last two days, I had a nurse on the late shift who was very competent. She was explaining everything to her [another woman in her room] as it were and suddenly I understood it all too and thought ah, ah and a lot of things just became clear”. This example shows that information was not always clearly conveyed and caused misunderstandings and dissatisfaction.

Women wanted to take over caring tasks but there were limitations as long as they felt physically constrained and exhausted. Additionally, women felt clumsy when they compared their own abilities with those of the nurses who were competently and quickly carrying out childcare. Experimenting with childcare was valued by Flavia (p162) as it was important to her to develop her own approach. Other women intentionally pushed for discharge in order to be on their own. ‘Enabling’ in this respect meant allowing women to experiment and so to become secure in their performance and to reinforce confidence in their abilities.

Several accounts in the data chapters, in particular in the section ‘Involving women’s partners’ give evidence that partners received guidance in childcare from the nurses. These activities were ‘enabling’ partners to support the women and complied with the expectations women articulated prenatally and contributed to their satisfaction with received care. However, further involvement of partners in caring tasks was not the norm. In this respect, Nurse Noelle said: “I don’t really think about involving the father with breastfeeding”. Furthermore, only a few partners were present at the discharge talk. Such conditions lead to the conclusion that the new family is not regarded as the unit of care.

‘Enabling’ also means maintaining confidence by coaching women in their capabilities. There was a relapse in confidence noticeable shortly before discharge. Facing the reality of being left on their own at home, most women in this study stated feelings of anxiety, loss and self-doubt, for example Flavia (p167) and Britta (p211). There was uncertainty of how they would cope with the responsibility and how they

would get enough sleep. The fact that they were now a family caused joyful feelings but also concerns of how they would adapt to the new social structure. Nurses made many efforts to provide information about the time afterwards and to build a link to the professional network in the community. However, it became evident from the women's accounts that they were left with those distressing feelings. Britta recounted her situation as follows: "I wasn't able to cope with too much, I suddenly did burst out in tears". Such experiences call into question the marginalisation of hospital care, which provides a safe environment away from everyday reality. Once at home, women are suddenly left without any structured professional care. As demonstrated throughout the first data chapter, there are many occasions on women's journeys through the postnatal care setting which clash with their journeys to motherhood.

Prior to discharge, participating women were eager to clarify questions revolving around caring issues and available care in the community. Such information was given throughout the days in postnatal care and was completed in the discharge talk. The few discharge talks I could observe were of diverse length and quality. Depending on the nurses' expertise, issues varied widely. Nurses Maja and Jennifer (p200) presented a contrasting attitude in respect of addressing for example self-care and sexuality issues. Whereas Maja placed those issues on the doctor's agenda, Jennifer took on full responsibility to inform the women herself. However, the course of action was also determined by the interests of the women, and their partners if the latter were present. Beside health and care-related issues, inquiring about the social network and explaining how to approach professional care were of concern to nurses. Kirstin's and Liana's examples (p216) demonstrate that most women had a well-established social network, which they could draw on if they wished. Professional care was mainly accessed at the parental clinic, which is best known within this socio-cultural context and operates on regular service hours. However, in a few cases women contacted the postnatal unit to ask for advice. Midwifery service or consultation at lactation consultants were not options chosen by the women. This might well reflect the fact that women have to make an effort to organise such support themselves. Furthermore, these services are not on the top of nurses' recommendations and also not comprehensibly recognised by new mothers.

Therefore, it is essential that nurses make a link from hospital-based care to the care services available in the community.

Information was the key to understanding the flow of things. 'Enabling' women entails provision of information about aims and interventions, the condition of woman and baby, the procedure and the setting. This was essential in order to provide the women with a complete picture about their care and of their situation in the unit. In the course of hospitalisation, women expected to become fully responsible and be able to make decisions, which inevitably required information. 'Enabling' also entailed making a link to community services and support from their social network.

Summary

The journey to motherhood and the journey in the liminality of a postnatal care setting are illustrated by the views of women and nurses and present a dichotomy. Women as first-time mothers are in a vulnerable state coping with an entirely new experience and new responsibilities, which makes them dependent on professional and lay support.

The five caring processes outlined above provided a useful framework to discuss postnatal care. During the time on the unit, practical care featured prominently but emotional care was the underlying component for gaining confidence. Women identified care provision as satisfying their needs but some problems were not wholly addressed. Organisational aspects were perceived as impeding emotional and physical recovery. The role of a nurse is to ensure that first-time mothers successfully go through their journey on the postnatal unit, which entails attending to their individual transition processes. Women and nurses valued a continuous allocation which ensures individual care and this resulted for nurses in greater job satisfaction. Professional experience and sound knowledge allowed nurses to support competently women in all aspects of care. Women realised whenever competent care was missing and for nurses this caused reflective thinking on their caring behaviour. In that respect students demonstrated that they were less skilled and their knowledge

base was not sufficient to meet the standard of care defined in the unit's guidelines. Moreover the students' ability to evaluate and reflect on their caring practices was insufficiently developed. Interesting findings were fragmented care, a lack of family-centeredness and the coincidence of discharge and feeling low. This calls into question whether this form of in-hospital care is still appropriate for women becoming and being a mother. I would argue that postnatal care needs to be reconstructed so that women's and hence their families' needs can be met more satisfactorily. This implies a move from in-hospital care to home and the community at an early stage postnatally. However, any potential changes in postnatal care provision should take the cultural context in which this study was based into consideration, before making any recommendations.

Implications for Nursing Practice, Research and Policy

In the preceding part of this chapter, I broadly outlined the results of this ethnographic study. My central concern was to explore and describe the experiences of postnatal care of a group of first-time mothers and the conduct of allocated nurses in one particular setting. As I have shown in the reflexive notes there are limitations caused by the research design which inevitably lead to limitations in concluding beyond the obtained data. Nevertheless in the following section I suggest how my understanding of the results can assist nurses to change and improve their care of women as first-time mothers, and what might need to be considered in terms of nursing and midwifery education. In addition, I outline directions for further research and policy.

Implications for nursing practice and education

This research work aimed to increase the body of knowledge in the nursing domain by investigating how the participating women experienced postnatal care in relation to their needs. I identified that a variety of difficulties were experienced. In this liminal phase, women are on two dissimilar but intertwined journeys: the individual transition to motherhood in which women's vulnerability is high and when their new

self as a mother is not yet well established: and the spatial journey on the postnatal unit, where adjustment and compliance are required. In the data, aspects of these journeys and the dissonances that occurred are highlighted, bringing out the complexity of postnatal care. The ultimate consequences in a social respect can be regarded as critical as most women and nurses were struggling to make sense of their personal and collective roles. What then are the implications for nursing academics and practitioners? The recommendations are that extended knowledge of the specific processes may assist nurses to accompany women on their journeys. Furthermore, it may facilitate nurses' assessment of women and their subsequent development of appropriate care plans.

The women as well as the nurses in this study addressed the importance of a relationship in which the two parties can trust each other. Such a relationship facilitates acquisition and strengthening of women's confidence in respect of their role and in acquiring caring skills. Since this process can not be linear, specific attention needs to be given to women's confidence throughout postnatal care. The concurrence of women's mood change and discharge needs attention as well as the integration of women's partners beyond mere childcare teaching. The latter may be seen as an important issue in assisting women in taking on their responsibility. Currently, a women-centred care approach is largely in place, however the focus is strongly on childcare issues and women's physical and emotional needs are insufficiently addressed. Moreover, promoting fathers' involvement beyond childcare may help them to bond with their baby. The introduction of family nursing (Whyte, 1997; Wright and Leahey, 2000) could be used in post-diploma education and continuing professional development to enhance professional practice and position the family as the focus of nurses' work rather than the individual or the mother-child dyad. Making the family the focus of postnatal care and education might facilitate the transition from being a couple to a family.

The study clearly demonstrates the need for rest and recuperation for the participating women and suggests that nurses generally respond sensitively to that need. However, there are indications that women feel exhausted after labour and birth and that the day-to-day routine as well as the busyness of the environment allows insufficient time and space to restore their full strength. In this respect a

review of the professionals' day-to-day routine is proposed, as well as an examination of structural influences to better support women in their need for rest and recuperation.

Continuous and consistent care within the postnatal care setting was well recognised by participating women and advantages of this were addressed by both women and nurses. These aspects not only contribute to quality care but also result in satisfaction for women with the provision of care. Some of the women's articulate descriptions of caring incidents illustrate nurses' behaviour and the effects this had on them. Although the women said that care had been of an acceptable standard, there were indications of inadequate performance which had left them with feelings of discontentment. On the other hand, continuous allocation to women proved satisfactory to nurses. This inevitably leads to the suggestion that continuity of carers and continuity of care would serve the care receivers as well as the care providers. Since such a recommendation is not new, attempts have to be made to inquire as to how such an approach can best be applied in a work environment where frequent changes in allocations of staff to particular shifts are the norm.

Findings from this study provide evidence that nursing and midwifery students were insufficiently prepared for postnatal care. This suggests that concepts of postnatal care as well as reflective learning need to be included in the curriculum before their placement on postnatal care units. Furthermore, closer supervision of students in their day-to-day practice is suggested to support them in learning to care for first-time mothers and to secure quality of care.

Implications for further research

The ethnographic design of this study is a strength in that it highlights the dialectic of postnatal care for first-time mothers and shows organisational and structural influences on experiences and care provision. The gaps identified indicate that much has to be done in terms of researching postnatal care provision. However, the area of maternity care depends greatly on the structure of the particular health care system in which it occurs. Thus, changes need to consider the historical development and the social structure of a society and the structure of service provision.

In the light of current developments in health care in Switzerland, a reorganisation of the postnatal care service is essential. As health care policy is politically driven, consideration needs to be given to which care approach would best serve first-time mothers and new families. A greater understanding of the needs of first-time mothers as well as families within the particular culture is required to provide a base for changes. A longitudinal study is needed to capture those needs for postnatal care provision. With such an approach, specific aspects of in-hospital postnatal care and any repercussion for community-based professional support could be addressed.

This study suggests that in-hospital postnatal care covers first-time mothers' needs to some extent and that a structured community-based support system is not yet in place. Lately, early discharge after birth has been proposed by health care insurers and policy-makers. In this respect, Beck and Knoth (2003) suggest a follow-up study to assess costs and benefits, effects on physical and emotional well-being in the first year post-birth and effects on the family and satisfaction of women. Such an investigation would shed light on professional support needs in the community.

Implications for policy

Women's perception of a patient-like role in the liminality of this setting is influenced socio-culturally and moreover characterised by the current attitude of medicalised childbirth. Such a conceptualisation placed the group of women in this study in a dependent position where their autonomous actions were limited at times. Mere information, at times insufficient, cannot be enough to contribute to informed decision-making. This suggests that all professional groups involved might need to reconsider how women and their partners can best be supported in their autonomous status and their attempts to assume their new responsibilities.

The organisation of maternity care revealed limitations in continuous women-centred care provision. Traditionally, maternity care has been in the domain of midwives. However, over the last decades this has changed as a fragmented service is now the norm. It is clear that this was more for the convenience of the professionals involved in this process than for the benefit of women. Although nurses on postnatal units are

qualified to perform competently, such a division of care provision causes deficiencies. Closer collaboration of the two professional groups would allow postnatal issues to be addressed in antenatal classes and also help women to cope with their birth experiences. Postnatal care, considered to be the least attractive part of maternity care, could benefit from a cooperative approach resulting in greater satisfaction for the professionals. Finally, focusing on the whole childbearing process and aiming at the smallest possible fragmentation of care would favour a family-centred care approach. This indicates a rethinking of postnatal care service which would be in the best interest for the service users being in this respect the new family.

Current developments derived by political and economic pressure constantly impose a reduction of the length of hospital stay post-birth, which has an impact on hospital based care provision. Although this is an external factor, this study also raises questions about the appropriateness of in-hospital care as it is structured and organised now. It therefore suggests a strategic development of appropriate service provision with the goal of ensuring the best possible care. In many Western countries where early discharge post-birth is the norm, a structured follow-up procedure is established. However, in Switzerland there is a lack of community-based follow-up programmes for women postnatally. Additionally, new families may no longer be able to rely on support from their social network since demography has altered extensively over the last decades. A fundamental reorganisation of postnatal care provision may be needed for successful changes in this area. Such changes including a well-established professional support network would contribute to a more family-friendly approach to postnatal care. Such an emphasis would do justice to the view that families are the nucleus of a healthy and well-functioning society, which will otherwise remain mere rhetoric.

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APPENDIX ONE

CONSENT FORM FOR FIRST-TIME MOTHERS

CONSENT FORM FOR FIRST-TIME MOTHERS

Consent to participate in a study of the experiences of first-time mothers in the first days after birth and the care received in hospital

The study is to be conducted by Irena Anna Frei. From 1993-1998 she was employed at the maternity clinic in [name of the city] as a Clinical Nurse Specialist. She is currently studying for a PhD in Nursing Science at the University of Edinburgh. The study is being supervised by two of the University's lecturers: Dr Rosemary Mander of the Nursing Studies Department and Dr Ian Dey of the Social Policy Department. The Chief Nursing Executive and the Clinical Director of the Clinic of Obstetrics of the [name of the hospital], as well as its ethics committee, have given their permission for the study to be conducted.

I am aware that this study will examine my experiences as a first-time mother in the first days after the birth of my child, as well as the care I receive on the postnatal unit.

Participating in this study means: I will be interviewed twice by the researcher. The first conversation will be conducted around two weeks before the birth and the second around two weeks after discharge from hospital. Both conversations will take place in my home, or in an office at the hospital if I wish. The conversations will be recorded on tape and a transcript will then be made. I can see this text if I wish.

I will be observed for three days after the birth. Observation will only take place at the times when the nurse is looking after me and my child. Notes will be made on what happens and on the conversations between me and the nurse. Irena will look at the documents related to my care and photocopy them.

The tape recordings and the documented information will be dealt with in the strictest confidence and kept in a locked place. The tapes and copied documents will be destroyed one year after the end of the study. Names will be replaced through pseudonyms in order to make it impossible to identify people or places.

Before the observation period, I will be asked again if I am still prepared to take part in the study. I can withdraw from the study at any time. I am free to decide whether to answer questions or discuss themes.

I am aware that I will not stay in the study if for any reason I am unable to care for my child by myself. The decision to participate in this study or not will have neither a positive nor a negative effect on the care of my child and myself. I will receive the same care as I would if I had not been approached to participate in this study.

After my participation has ended, I will be given the chance to look at the results of the conversation with me and the observation and discuss them with the researcher. A copy of the final report will be made available to me.

I am aware that the study or parts of the study will be submitted for publication in national and international professional journals and that these will also be presented at conferences for members of the health care professions.

I am also aware that the researcher will not carry out any nursing duties during her observation time in the hospital. If I do ask her any questions, she will refer me to the nurse responsible for my care.

I am aware that if I have any questions about the study or the consent form, I can contact the researcher.

Contact address:

Irena Anna Frei, [full address and phone number]

Signatures:

Participating woman _____ Irena Anna Frei _____

Date: _____

One copy of this consent form stays with the participant, and one copy goes to the researcher.

APPENDIX TWO

CONSENT FORM FOR NURSES

CONSENT FORM FOR NURSES

Consent to participate in a study of the experiences of first-time mothers in the first days after birth and the care provided in hospital

The study is to be conducted by Irena Anna Frei. From 1993-1998 she was employed at the maternity clinic in [name of the city] as a Clinical Nurse Specialist. She is currently studying for a PhD in Nursing Science at the University of Edinburgh. The study is being supervised by two of the University's lecturers: Dr Rosemary Mander of the Nursing Studies Department and Dr Ian Dey of the Social Policy Department. The Chief Nursing Executive and the Clinical Director of the Clinic of Obstetrics of the [name of the hospital], as well as its ethics committee, have given their permission for the study to be conducted.

I am aware that this study will examine the experiences of first-time mothers in the first days after the birth of their child, as well as the care they receive on the postnatal unit.

Participating in this study means: Irena will observe me as I care for a woman who has decided to participate in this study. The observations will take place in the first days after birth and will each last for the duration of a shift (early or late shift). Irena will make notes on what happens and the conversations between me and the participating woman.

I will be interviewed once by Irena. The conversation will take place after the shift where I have been looking after a participating woman. This will take place in an office in the hospital, or if I prefer, in a place of my choosing. The conversations will be recorded on tape and a transcript will then be made. I can see this text if I wish.

Irena will also look at the documents relating to the care of the participating woman and photocopy them.

The tape recordings and the documented information will be dealt with in the strictest confidence and kept in a locked place. The tapes and copied documents will be destroyed one year after the end of the study. Names will be replaced through pseudonyms in order to make it impossible to identify people or places.

I can withdraw from the study at any time. If I do not participate in the study or withdraw, this will have no effect on my relations with my employers. I am free to decide to answer questions or discuss themes at greater length.

After my participation has ended, I will be given the chance to look at the results of the conversation with me and the observation and discuss them with Irena. A copy of the final report will be made available to me.

I am aware that the study or parts of the study will be submitted for publication in national and international professional journals and that these will also be presented at conferences for members of the health care professions.

I am aware that Irena will not carry out any nursing duties during her observation time in the hospital.

I give my consent voluntarily to be involved in the study

Contact address:

Irena Anna Frei, [full address and phone number]

Signatures:

Participating nurse _____ Irena Anna Frei _____

Date: _____

One copy of this consent form stays with the participant, and one copy goes to the researcher.

APPENDIX THREE

PROFILE OF PARTICIPANTS

PROFILE OF PARTICIPANTS

Women's name; age, profession, nationality and type of birth	First day of observation; Nurses' name, age and professional qualification	Second day of observation; Nurses' name, age and professional qualification	Third day of observation; Nurses' name, age and professional qualification
Alicia; 31 Medical Doctor German Spontaneous vaginal birth	Larissa, 22; first year nursing student	Larissa, see left	
Britta; 29 Clerical Swiss Spontaneous vaginal birth	Carla, 32; Diploma in general nursing obtained in 1990	Leah, 22 Diploma in integrated nursing obtained in 2000	Muriel, 22 Fourth year nursing student
Carol, 26 Health care assistant Swiss Caesarean birth	Ladina, 31 Diploma in children's nursing obtained in 1990	Sanna, 29 Diploma in children's nursing obtained in 1993	Helena, 30 Certificate Baby- and postnatal nurse 1993; Diploma in integrated nursing obtained in 1998
Diana, 29 Primary school teacher Italian/Swiss Caesarean birth	Marika, 22 First year midwifery student	Angela, 25 Diploma in general nursing obtained in 1997	Marika
Eleonora, 27 Nurse and Practice Nurse Technically assisted vaginal birth African/Swiss	Naomi, 19 First year nursing student	Leah, see above	Leah, see above

Flavia, 23 Industrial Seamstress and home help Swiss Spontaneous vaginal birth	Jennifer, 48 Diploma in children's nursing obtained in 1975	Jennifer, see left	
Giovanna, 28 Nurse Swiss Spontaneous vaginal birth	Fabienne, 29 Diploma in children's nursing obtained in 1994	Noelle, 36 Diploma in children's nursing obtained in 1986	
Hanna, 29 Psychologist Swiss Spontaneous vaginal birth	Maja, 41 Diploma in children's nursing obtained in 1980	Carla, see above	Laura, 20 First year nursing student
Kirstin, 35 Language teacher English/Swiss Caesarean birth	Barbara, 50 Diploma in children's nursing obtained in 1972	Esther, 37 Diploma in children's nursing obtained in 1985	Bettina, 23 Diploma in integrated nursing obtained in 2000
Liana, 21 Home economics teacher Greek/Swiss Spontaneous vaginal birth	Simona, 22 Third year midwifery student	Larissa, see above	Anja, 59 Diploma in children's nursing obtained in 1963

APPENDIX FOUR

CONVERSATION GUIDE

CONVERSATION GUIDE: Information and questions for the initial conversation with the women

- Questions about the consent form; Is it possible to give consent?
- Explanation of the study and the process (length, questions, tape recording) of the interview and the observation
- No information concerning the content of the conversation to be given to nurses
- Midwife or nurse will inform me about the birth (the woman doesn't need to phone me).

- How are you at the moment? Could you tell me a bit about it?
- How has your pregnancy been so far?
- What kind of emotional changes have you noticed during your pregnancy?
- How have you managed to adapt to these changes?
- Are you in contact with other first-time mothers and if so, what have you learned and what do you think about what you've learned? What does it mean for you?
- Are there any other factors which have influenced your experiences and expectations in some way?
- How do you think you will feel as a first-time mother?
- Meaning of being a mother?
- Did you go to prenatal classes and if so, what did you learn through them?
- Have you had any experiences as a patient or with the hospital?
- How do you imagine the first days after the birth will be?
- What kind of support do you expect from your family and from professionals?
- What ideas do you have about the role and duties of the nurses? What do you think you can get from them in terms of support?
- Do you have any plans for employment after a certain period of time and if so, what are they?
- Is there anything else you'd like to add or do you have any other questions?

APPENDIX FIVE

EXAMPLE OF FIELDNOTES

EXAMPLE OF FIELDNOTES

Set F: Flavia; Day One - Nurse Jennifer; Day Two - Nurse Jennifer

Initial Conversation with Flavia: Friday 9th June 2000

Thoughts on the conversation

A young woman, full of energy, meets me at the door and welcomes me warmly. There's a spring in her step as she invites me into the dining room. She tells me that she's feeling fine and very much looking forward to the birth of her first child. She's aware that she's still very young and says that people on the street sometimes look at her strangely. I gave her the chance to ask any questions she had about the consent form and then we're able to go straight into the conversation proper. It runs very smoothly as she likes talking but also takes time to really think about some of the questions. It seems to me that despite her young age, she's already thought in depth about many of life's issues. I feel good today, I got up easily and have the impression that I can lead her gently through the conversation.

Subsequent Reflection on the Conversation

Somehow I've gained a little more self-confidence in terms of these first conversations. I also don't have so many reservations about mentioning personal things about myself. I've also noticed that I have fewer difficulties with asking her very direct questions about what she says but also with responding to her questions. I find it difficult to make notes during the conversation, somehow it affects my concentration. I'm not going to do it in the future. There are a few places in the conversation where I notice that I'm trying to turn the questions round, especially when I realise that I started to ask a closed question. Have to watch out for that more. As a result of what she says, I feel that I'm succeeding in creating an open atmosphere. It doesn't become too personal, but doesn't stay distanced either.

- Elements for the observation:
- Time for relationship / rest
- Flavia feels generally confident
- Would like instruction in all new areas

- Contact with other mothers when possible
- Afraid of baby blues / post-natal depression

Observation; Wednesday, 5th July 2000, 7 am – 4 pm; First day with Jennifer

The night nurse reports that Flavia hasn't slept particularly well, she had backache but didn't ever call the nurse because of it. She says she offered her a massage but Flavia wanted to wait until her husband comes so he can do it. The baby has slept well. Jennifer talks to her about the night. Flavia complains of backache again. Jennifer offers her a compress and mentions that she should move about a bit. Later she describes some positions to lie in to relieve the pain and how she could do some breathing exercises.

Jennifer checks if she wants to have breakfast first and then have a shower. Flavia would rather eat in her room, Jennifer encourages her to go to the breakfast buffet as she's signed up for it and will meet other women there. Flavia is prepared to try it.

Flavia comes back from breakfast. Jennifer discusses the aims and structure of the day with her. She refers to yesterday and the arrangements (assessment interview, checks of woman and baby) and makes a suggestion about how she wants to incorporate everything into the day. Jennifer gives her two options for the next step, allowing Flavia to decide what she wants to do. Flavia seems open but not very certain. She's interested in finding out why things are done the way they are and makes it clear that today she'd like to concentrate on carrying out baby-care in order to become more confident with it.

Jennifer goes with her into the baby-care room. She instructs her in all the processes and shows her the material. She stays with her and offers a helping hand. As they work, they discuss anything that crops up: skin, products, turning the child, putting clothes on etc. She makes it clear that the use of skin care products should be kept to a minimum and tells her what her own preferences are. She explains why the products should be unperfumed. She leaves her a lot of space to try things out but does intervene very directly when she notices something, or the mother seems uncertain or has questions. The baby cries during the bath and also afterwards, it's not easy for Flavia to cope with. She'd like to feed the baby as soon as possible. In her room, Jennifer suggests that she should get ready for breastfeeding. Jennifer

comforts the baby so that the mother can prepare her breast. She lets Flavia try the latching on by herself. After a few attempts, it isn't working, so Jennifer supports her, mentions the importance of good preparation again and shows her how she can keep the baby calm. She tries to encourage Flavia to talk about how she's experiencing this situation and she praises her for what she's doing.

Flavia offers to have the assessment interview later, in case she [Jennifer] would prefer to talk to her neighbour first. Jennifer makes it clear that she wants to do the interview today, as she's already had plenty of opportunities to talk to the other woman. She says she'd have time for it after lunch. She also says that Flavia should comfort her baby a bit now as it clearly needs closeness or maybe needs winding. Furthermore there are visitors waiting at the door. Jennifer informs the women in the room that outside visiting hours, they should meet visitors outside, so that there's enough peace and quiet in the room. The women agree amongst themselves that it won't disturb them at the moment if someone comes in for a while. Jennifer carries out the checks and tells her what the results are.

Assessment interview: Jennifer organises a quiet room and arranges comfortable seating. The episiotomy is still causing Flavia a lot of pain and she can only sit on one buttock cheek. Jennifer outlines the aims of the conversation. She enquires how Flavia is feeling about being a mother. She mentions the tiredness, the baby blues and head and backache. Jennifer tells her that she appears to be doing well at the moment. Jennifer asks how she would assess the baby's situation. Flavia talks about her experience of birth and says it was generally positive, even if it was a long process. She says now she'd just like to give herself enough time and space to deal with the birth experience. In terms of breastfeeding, she says she's totally satisfied. Her nipples will need some attention in the coming hours and days. Flavia looks at the aims in "Attaining safety in childcare and the ability to breastfeed". Jennifer then mentions that Flavia should allow herself some peace and quiet while she's still here. They plan the discharge for Friday or Saturday.

Reflections on the first observation day

Jennifer has a structured and fast-moving approach to the day. She discusses the structure of the day in an open manner that allows Flavia to express her wishes. She

makes it easy for me to be present and her air of confidence is reassuring. It also allows her to deal with all three women in the room on an individual basis. She leaves the women space to concentrate on themselves and their babies. Flavia makes her priorities clear and is flexible in her plans, for example when an activity needs to be delayed. Jennifer is able to integrate me into the day's activities and I find it easy to distance myself from other things that happen in the room. I also have enough time to make notes on my observations.

Questions for the conversation with Jennifer:

- How did you feel about Flavia's care?
- In your view, what was the emphasis today?
- How would you assess her abilities?
- How do you know that she's applying the information you give her?
- How do you lead her to decisions?
- Situation with assessment interview: own needs, baby blues

Reflections on the conversation with Jennifer

Before the interview we had a quick chat about old times. I then switched to the real topic. Jennifer talks spontaneously and effusively about the situation with Flavia. Her descriptions conveyed her delight at working with the young women in the room. During the conversation, we also touched on the situation with a woman in a neighbouring room that was very trying for the women and nurses. Otherwise I was able to concentrate on the important parts of the morning.

Observation: Friday, 7th July 2000, 7 am – 4 pm; second day with Jennifer

At hand over, the night nurse mentions that Flavia has a lot of milk but is breastfeeding by herself. Flavia is still asleep but Jennifer wakes her as the paediatrician is coming to examine her after 8 o' clock. She justifies the early start by saying that she can go to the pelvic exercise classes at 11, as planned. Flavia says that she's slept badly and the baby came to her a lot/was brought to her a lot. She only really fell asleep a few hours ago. There had also been a bad storm in the night which had contributed further to the disturbances. Flavia asks about the strange

position the baby is lying in and Jennifer explains why; she says she'll show her what she can do about it later.

Jennifer seems to be hectic, she's interrupted twice and can't concentrate on the woman. After breakfast they discuss the structure of the day, what the emphasis will be and any questions. Flavia is very concerned about the large quantity of milk she has and what she can do about it. They discuss several ideas back and forth and decide to consult the breastfeeding advisor. Flavia would also like to pump some milk, Jennifer wants to know how she came up with the idea. What she mostly wants to do is relieve the pressure on her breast, which Jennifer can only support. The other things that are important for Flavia are being able to go to fitness class and then have some time for herself. She mentions that she was glad that she didn't have any visitors yesterday evening, apart from her husband. In terms of caring for her baby, she'd still like to have support in the background. She expresses some uncertainty regarding how she should hold the baby during certain interventions.

Jennifer fetches her for the examination with the paediatrician. She had had a shower and was ready with her baby. After that, Jennifer carries out the Minolta test and leaves the rest of the day up to her. She tells her that she should make sure she goes to the pelvic exercise class and ask for help if she needs it. Jennifer tries to fit a lot of activities into a certain time, in the interests of the woman as she says, but I think this can also increase the already high expectations of the woman.

Later, Jennifer is involved in questions about nutrition and what she should do when she's out and about with the baby. Jennifer tells me that she's noticed that Flavia sometimes gets distracted during conversations but she does take in what she's telling her. She's noticed that she needs a lot of rest and keeps retreating into herself. Flavia mentions to the paediatrician that she'd like to go home on Saturday. In the previous conversation, Jennifer had understood that she was thinking about possibly staying in for the weekend. Bearing the situation in mind, I found this really astonishing, but because I had problems hearing what she was saying, I'll have to wait for further discussions in order to find out what she's thinking. Jennifer makes sure that Flavia is ready for the fitness class and encourages her to just do what's good for her. She says she'll look after the baby during the class. She explains to her

how she can use pillows for example filled with millet to create an enclosed space to help the baby to feel secure.

Discharge talk: Jennifer explains the function of the talk to her and asks her what expectations she had and whether they've been realised. She wants to know how she's coping with her new role.

Flavia states that she's gained a lot of confidence and can try things out at home. Jennifer mentions discharge. She tells her that she had noticed her uncertainty regarding the discharge on Saturday.

Flavia shows her feelings and also says that she would like to go to a wedding tomorrow but was worried that she wouldn't be up to it. She's found a solution now though and will also be getting help from her sister in the first days at home.

Jennifer asks her how her mothering abilities have developed. She recommends visiting the parental clinic for support and contacts.

She also brings up the theme of being a woman and mother and discusses the following points with her:

- strengthening the pelvic floor
- circulation/respiration
- caring for the birth injury
- Baby massage
- sexuality and contraception
- relationship with her husband
- personal needs
- recovery and help
- changes in her body and sensibility

Flavia mentions that she has times when she feels sad, especially at the moment, but they pass quickly. Jennifer explains what warning signals she should watch out for at such times. Flavia adds that she is looking forward to being together with her husband and baby.

Jennifer takes a lot of time for the discharge talk and addresses the woman in her new role. Flavia tells her that she values being able to talk about it with her and the care she's given her over the last few days.

Reflection on the day

Jennifer is concentrating on the preparations for discharge and most of all the emotional support, as she has picked up on the woman's sensitivity. This is an aspect that Flavia had mentioned in our first conversation. She keeps finding opportunities to say something about it and also involves the other women in the room in the conversation. She works quickly, it is always clear what she's doing and she always fetches me when she's in contact with Flavia.

I feel good during this observation. The care I am observing seems to be very comprehensive and in that sense it's the first situation that's been like that.

- Questions for the conversation with Jennifer
- emotional situation
- Flavia's strong need for rest
- Discharge date
- Discharge interview – problems, being a woman and mother
- What developments can you trace over the days?
- How did you find the nursing care?
- Support at home?

Reflection on the interview with Jennifer

Jennifer talks spontaneously about the relationship with Flavia. She expresses herself well and also thinks about the background of this specific situation.

Final conversation with Flavia: 25th July 2000

Questions:

- individual elements from the first conversation
- emotional situation in hospital and now?
- Situation in room
- Nursing support with being a woman and mother
- Breastfeeding situation
- Social network

Reflection on the interview

Flavia was very open in this closing interview. She was prepared to reflect on how the situation had been in the hospital and how it was now, at home. She valued the possibility of this exchange and said how quickly time passed and how little time there was for thinking about things. I felt very comfortable with her.

Closing thoughts

In my view, the nursing situation with Flavia was ideal. Throughout her stay, there was a continuity of care with Jennifer and also the same night nurse. She realised this and also appreciated it a great deal. It emerged that her emotional state was not particularly stable, but both her partner and the nurses recognised this and supported her. She also managed to set clear boundaries with visitors and rewarded herself with “time out”. Her uncertainty at the end regarding discharge showed very clearly that she realised how important it was to be able to care well for her baby at home.